

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12084

12051

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 62 220 PACA STREET CUMBERLAND	
c. LENGTH OF STAY IN 1b 11 DAYS		d. STREET ADDRESS 1 220 PACA STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			
3. NAME OF DECEASED (Type or print) First FRANK Middle JOHN Last AMAN		4. DATE OF DEATH Month 11 Day 30 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/83
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener (Retired)		10b. KIND OF BUSINESS OR INDUSTRY City of Cumb.	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN AMAN	
14. MOTHER'S MAIDEN NAME ANNA BROOKS		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Clara A. Aman 220 Paca St., Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 163X DUE TO Coronary artery disease, Long Abscess, Pneumonia Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 1, 1960 to Nov 30, 61 , that (I) (we) last saw the deceased alive on 11/30, 1961 , and that death occurred at 11/30, 1961 , from the causes and on the date stated above.			
22a. SIGNATURE B. M. Schindler		22b. DATE SIGNED 12/1/61	
22c. PHYSICIAN'S NAME (Type) DR. B. M. SCHINDLER		22d. ADDRESS 43 GREENE STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Dec. 4, 1961	23c. NAME OF CEMETERY OR CREMATORY St. Patrick's Cem.	23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE DEC 5 '61	
		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 12-15-2001 BY 60322 UCBAW/BJS/STP

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Tlien please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

12065

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12052

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND, d. STREET ADDRESS 301 PULASKI STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JANE WILLIAMS AMSTUTZ		4. DATE OF DEATH Month NOVEMBER Day 12 Year 19 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 12, 1890
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE WILLIAMS		14. MOTHER'S MAIDEN NAME ELIZABETH WALTERS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause or two for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arteriosclerosis DUE TO (c) Diabetes Mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 3 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 p.m. 9		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-9-61 to 11-12-61 that (I) (we) last saw the deceased alive on 11-11-1961 and that death occurred at 4:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE W. F. Williams M.D.		22b. DATE SIGNED 11-12-61	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/61	
23c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		23d. LOCATION (City, town or county) (State) Frostburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		25a. REC'D BY REGISTRAR NOV 16 '61	
25b. REGISTRAR'S SIGNATURE Charles E. House			

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VR A15 (4)
15M 9/60

DR. LEY

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12066

CERTIFICATE OF DEATH

12053

Item 8 Film G-302 12/13/61 iwk

1. PLACE OF DEATH a. COUNTY <i>Allegany County</i> MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN 1b 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL AVE., CUMBERLAND, MD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>GARRETT</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MARYLAND d. STREET ADDRESS 11X-2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last MARTHA J. BEEMAN		4. DATE OF DEATH Month Day Year NOVEMBER 30 1961		9. AGE (In years last birth day) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1890 DEC. 14 11/89/1		10. AGE (In years last birth day) 70 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? US U.S.							
13. FATHER'S NAME BITTINGER, LEVIE				14. MOTHER'S MAIDEN NAME BESSIE TROUT				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Coronary Occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerotic cardiac - Vascular disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH Minutes 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <i>Nov 25, 1961</i> to <i>Nov 30, 1961</i> , that (I) (we) last saw the deceased alive on <i>Nov 30, 1961</i> , and that death occurred at <i>7:20 PM</i> on the causes and on the date stated above.													
22a. SIGNATURE <i>G. O. Himmelwright MD</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 12/1/61							
22c. PHYSICIAN'S NAME (Type) XXXXXX DR. G.O. HIMMELWRIGHT				22d. ADDRESS 133 VIRGINIA AVE. CUMBERLAND, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 12/4/61		23c. NAME OF CEMETERY OR CREMATORY DURST		23d. LOCATION (City, town or county) (State) GRANTSVILLE GARRETT CO MD							
24. FUNERAL DIRECTOR'S SIGNATURE <i>Don Newman</i>				ADDRESS Grantville, Md		25a. REC'D BY REGISTRAR DATE DEC 7, '61		25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>					

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1903



GENERAL HOSPITAL, CHICAGO

GRANTVILLE, ILLINOIS

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DEPT. OF HEALTH, CHICAGO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 3 File G302 12/4/61 jwk

12054

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND, MARYLAND		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BLOOMINGTON, MARYLAND	
c. LENGTH OF STAY IN 1b 22 days		d. STREET ADDRESS 11X-2	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle DAVID W. BEVER		4. DATE OF DEATH Month Day Year 11 22 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-4-20
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR: Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME WILLIAM S. BEAVER (D)		14. MOTHER'S MAIDEN NAME LAVERA BEAVER(D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. CHART	
17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO (b) Adenocarcinoma stomach with Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) metastases		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-31-61 to 11-22-61 that (I) (we) last saw the deceased alive on 11-20-61 , and that death occurred 11-20-61 from the causes and on the date stated above.			
22a. SIGNATURE Earl R. Paul M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) EARL R. PAUL M. D.		22d. ADDRESS 36 GREENE STREET CUMBERLAND, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/61	
23c. NAME OF CEMETERY OR CREMATORY Garrett Memorial Gardens		23d. LOCATION (City, town or county) (State) Oakland Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Earl R. Paul ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR DATE NOV 27 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12068

12055

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG c. LENGTH OF STAY IN 1b 1 WEEK d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MINERS HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROUTE 1, FROSTBURG d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MINNIE Middle S. Last BRODE				4. DATE OF DEATH Month NOVEMBER Day 22ND , Year 1961					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 19TH, 1896		9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOUSEWORK		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM SITTIG				14. MOTHER'S MAIDEN NAME MINNIE BRODE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. WM. BRODE, JR., FROSTBURG, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hypertension								INTERVAL BETWEEN ONSET AND DEATH 36 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, term, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Nov 21, 1961 3:45 PM to Nov 22, 1961 11:00 AM , that (I) (we) last saw the deceased alive on Nov 21, 1961 , and that death occurred at Nov 22, 1961 , from the causes and on the date stated above.									
22a. SIGNATURE W O McLane				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED Nov 22 1961		22c. PHYSICIAN'S NAME (Type) W. O. McLane		22d. ADDRESS 167 E. MAIN ST., FROSTBURG, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-24-61		23c. NAME OF CEMETERY OR CREMATORY F'BG. MEMORIAL PARK		23d. LOCATION (City, town or county) (State) FROSTBURG, MD.			
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Burst				ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR DATE NOV 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1905

1905



1905

1905



1
FOR STATE
HEALTH DEPT.

TO THE DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form M-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

120669 12056
Item 1 Film G302 12/07/61 iwk

1. PLACE OF DEATH
COUNTY ALLEGANY MARYLAND

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MD. b. COUNTY BALTO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) STENMIERS RUN
d. STREET ADDRESS Box 254 Rt 15
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) VERNON H. CARR SR.
First Middle Last

4. DATE OF DEATH Nov. 18TH 1961
Month Day Year

5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐ 8. DATE OF BIRTH APR-7-1895
WIDOWED ☐ DIVORCED ☐ 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AUTO BUSINESS RETIRED 10b. KIND OF BUSINESS OR INDUSTRY W. VIRGINIA 11. BIRTHPLACE (State or foreign country) W. VIRGINIA 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME PERRY CARR 14. MOTHER'S MAIDEN NAME MOLLIE P

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 212-34-9331 17. INFORMANT HOWARD CARR (SON) Address SAME AS ABOVE

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY OCCLUSION
+ 20.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY SCLEROSIS
DUE TO (c) ---

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) --- 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18) ---

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) --- 20f. (City or town) (County) (State) ---

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒ and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DATE SIGNED NOVEMBER 18, 1961
DEPUTY MEDICAL EXAMINER ☒ ADDRESS (Street, city, town, or county) RD 9 Cumberland, MD.

ACTUAL SIGNATURE Benedict Skitarelic M.D. EXAMINER'S NAME (Type) BENEDICT SKITARELIC

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF 11-22-1961 22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery 22d. LOCATION (City, town, or county) (State) Balto Co. Md.

23. FUNERAL DIRECTOR John G. Connolly ADDRESS 418 Eastern Blvd Balto 21 24a. REC'D BY REGISTRAR NOV 27 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12070

CERTIFICATE OF DEATH

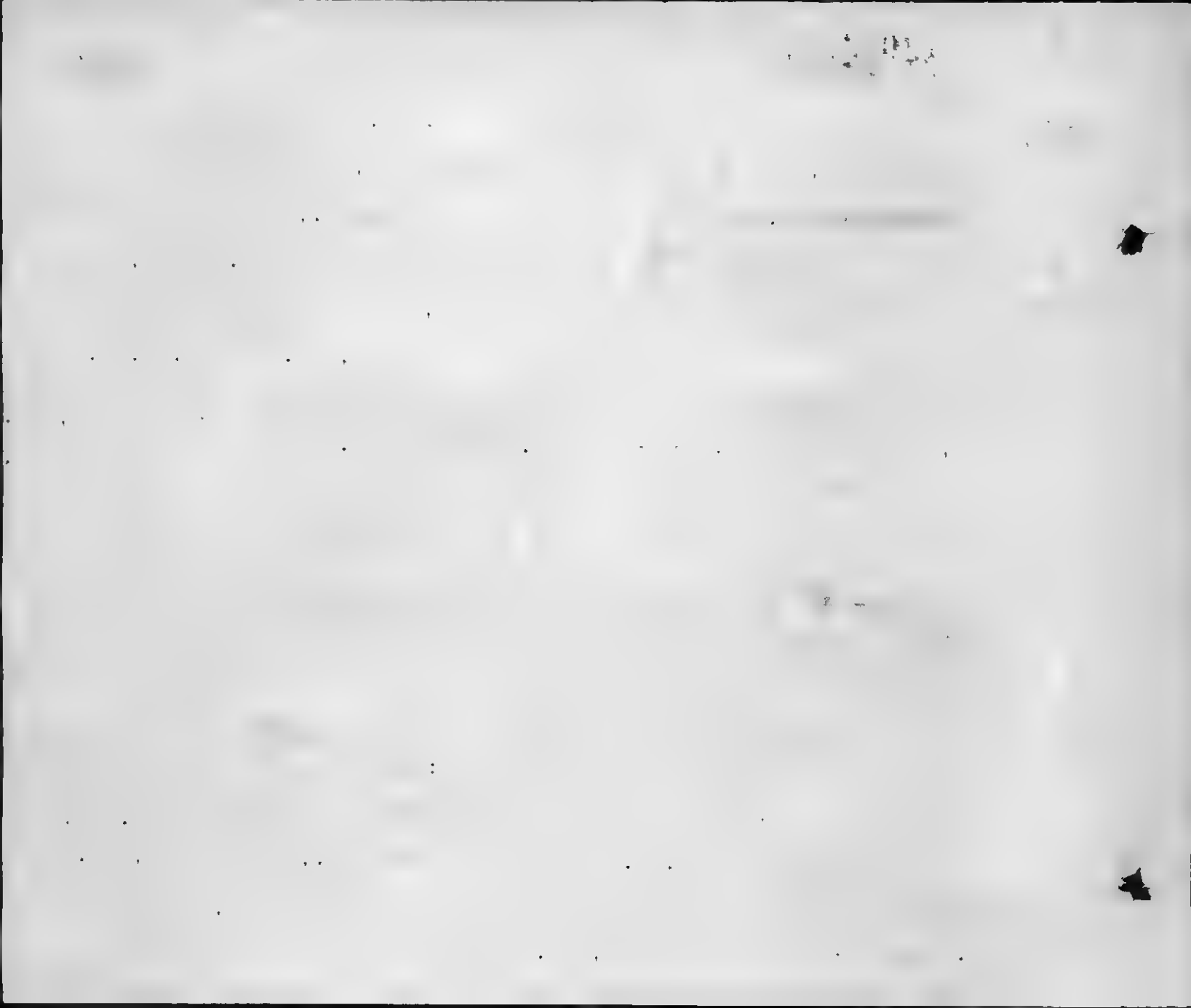
12057

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Sacred Heart Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE W. Va. b. COUNTY Mineral ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ridgeley d. STREET ADDRESS 7 Martin St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Bernard Morgon Clarke		4. DATE OF DEATH Nov. 22, 1961	
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH April 22, 1889 9. AGE (In years last birthday) 72 yrs. 10. KIND OF BUSINESS OR INDUSTRY Iron Worker 11. BIRTHPLACE (Country & State, or foreign country) Cumberland, Md. 12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George Clarke 14. MOTHER'S MAIDEN NAME Eleanora Morgon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. 16. SOCIAL SECURITY NO. 232-09-5878 17. INFORMANT Mrs. Elizabeth O. Stogdale Address Hyattsville, Md. 4233 Oglethorpe St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the rectum DUE TO (b) Cancer of the bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. I certify that (I) (this hospital) attended the deceased from 3-4-1961 to 11-22-1961 that (I) (we) last saw the deceased alive on 11-21-1961 and that death occurred at 3:30 A.M. from the causes and on the date stated above.		22a. SIGNATURE Lewis Brings M. D. 22b. DATE SIGNED Nov. 22, 1961 22c. PHYSICIAN'S NAME (Type) Lewis Brings M. D. 22d. ADDRESS 57 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11/24/61 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park 23d. LOCATION (City, town or county) (State) Cumberland, Maryland		24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md. 25a. REC'D BY REGISTRAR DATE NOV 24 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please move carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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12071

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12058

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 9/14/1961			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. STREET ADDRESS 34 Grand Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Julia Middle Alberta Last Colbert				4. DATE OF DEATH Month November Day 6, Year 1961			
5 SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/18/1888		9. AGE (In years last birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Clarence Slippy				14. MOTHER'S MAIDEN NAME Elizabeth Reitz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO None		17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, decompensating DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dickinson, Ill. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/14/61 19 to 11/6/61 19, that (I) (we) lost saw the deceased alive on 11/4/61 @ 6:30 P.M. and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Dr. Lee B. Mathews				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 11/6/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 8, 1961		23c. NAME OF CEMETERY OR CREMATORY Mc Intyre Cemetery		23d. LOCATION (City, town, or county) (State) Holidaysburg, Penna.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR NOV 9 '61		25b. REGISTRAR'S SIGNATURE Charles E. Hines	

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1944

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

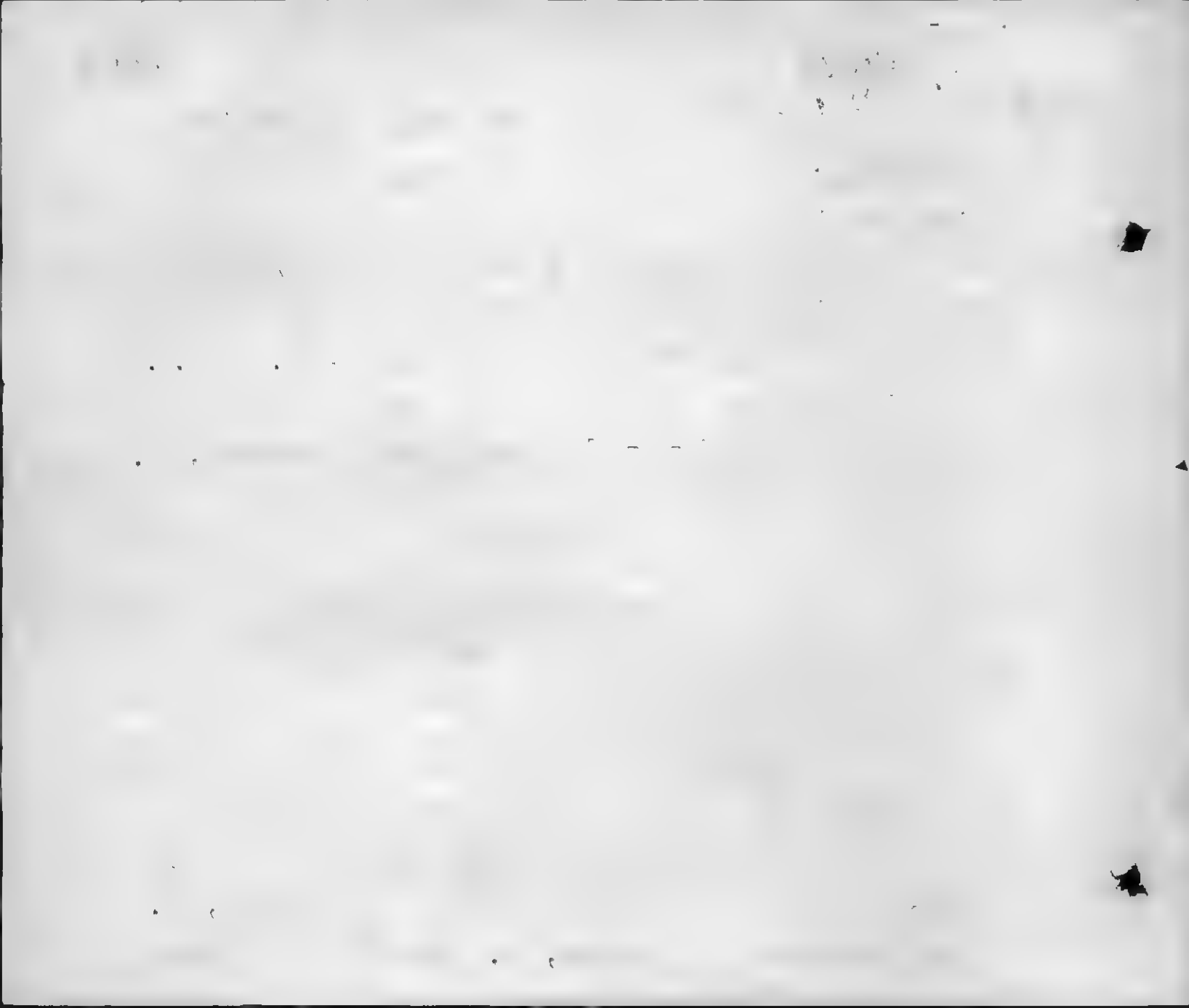
CERTIFICATE OF DEATH

12072

12059

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. COUNTY Allegany Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) MARGARET COLEEN COLMER		4. DATE OF DEATH 11/25/1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/28/1939
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months 11 Days 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE (County & State, or foreign country) Vale Summit, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Britt Buckalew		14. MOTHER'S MAIDEN NAME Mary Hansel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-38-5814	
17. INFORMANT Harry Colmer (Husband)		Address Midland, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 11 Chemia DUE TO Rheumatic heart disease with mitral stenosis 8 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocarditis - Acute Liver Congestion & jaundice		19. INTERVAL BETWEEN ONSET AND DEATH 3 mos.	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) June 1961, to Nov. 25, 1961		20f. (City or town) (County) (State) Midland, MD.	
21. I certify that (I) (this hospital) attended the deceased from... June 1961, to Nov. 25, 1961 , that (I) (we) last saw the deceased alive on... Nov. 25, 1961 , and that death occurred at 9:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE L.R. Miles, Jr.		22b. DATE SIGNED NOV 25 1961	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS LONACONING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/61	
23c. NAME OF CEMETERY OR CREMATORY Vale Summit Cemetery		23d. LOCATION (City, town or county) (State) Vale Summit, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHORN		25a. REC'D BY REGISTRAR NOV 29 '61	
ADDRESS LONACONING, MD.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

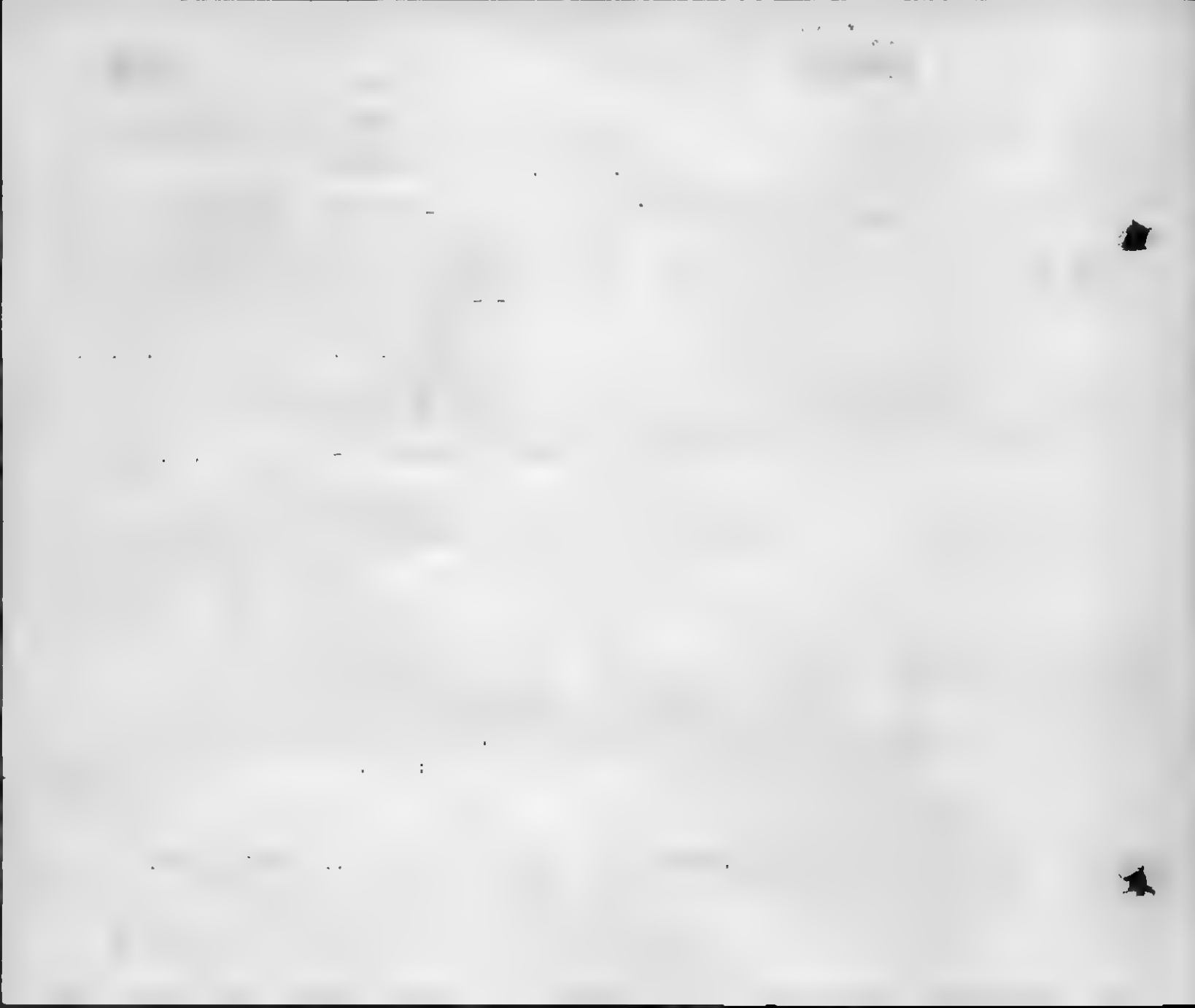
12073

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12060

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY N 1b 12 HRS. 6 MIN. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 7-D JANE FRAZIER VILLAGE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NOEL PATRICK CONLEY		4. DATE OF DEATH NOVEMBER 7, 1961	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-7-1961	
9. AGE (In years last birthday) 12		10. AGE (In years last birthday) 6	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME NOEL CONLEY		14. MOTHER'S MAIDEN NAME ANNA MAE CROSS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxiation due to Aspiration of blood Conditions, if any, which gave rise to immediate cause (b) Intrauterine bleeding due to Abruptio Placenta cause last, (c) 12 hrs		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7 Nov. 1961 to 7 Nov. 1961 , that (I) (we) last saw the deceased alive on 7 Nov. 1961 , and that death occurred at 7:25 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Leland B. Ransom		22b. DATE SIGNED 8 Nov 61	
22c. PHYSICIAN'S NAME (Type) DR. LELAND B. RANSOM		22d. ADDRESS 63 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/9/61	
23c. NAME OF CEMETERY OR CREMATORY HILL CREST BURIAL PARK		23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR NOV 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Frank			

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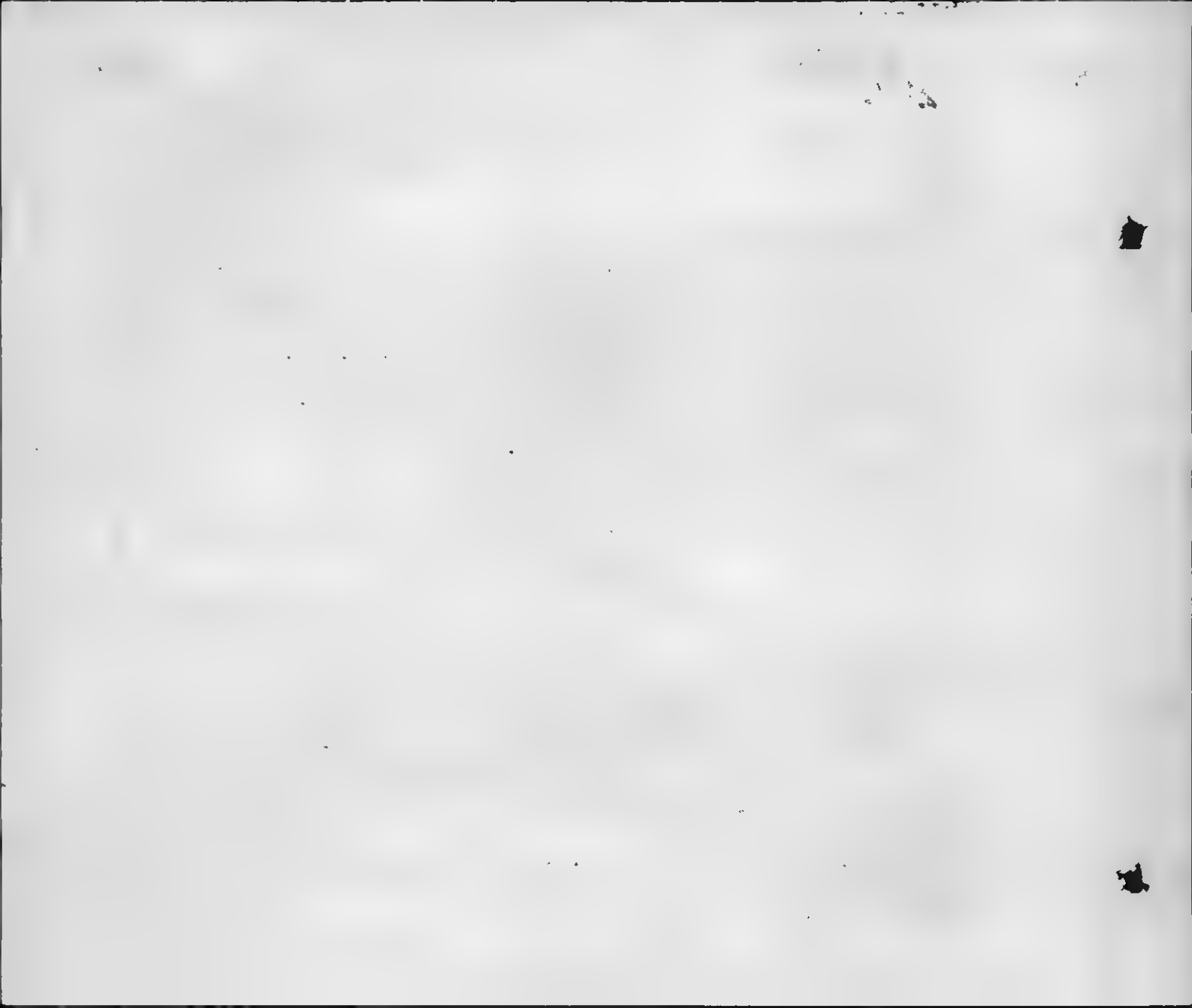


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12074 CERTIFICATE OF DEATH 12061											
1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1 month				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 362 Williams Street				d. STREET ADDRESS 362 Williams St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Abel M. Conner				4. DATE OF DEATH Nov. 11 19 61				5. SEX Male 6. COLOR OR RACE White			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH June 19, 1878				9. AGE (In years last birthday) 83 yrs			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Industry				11. BIRTHPLACE (County & State, or foreign country) Kingwood, W. Va.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Michael Conner				14. MOTHER'S MAIDEN NAME Elizabeth E. Burns			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 17				17. INFORMANT Mrs. F. De Sales King, Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) trauma DUE TO (b) myocardial infarction DUE TO (c) arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 hrs 2 yrs 5 yrs				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) No				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month. Day. Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home			
20f. (City or town) Nov. 9, 1961				20g. (County) Allegany				20h. (State) MD			
21. I certify that (I) (this hospital) attended the deceased from Nov. 9, 1961 to Nov. 11, 1961 ; that (I) (we) last saw the deceased alive on Nov. 9, 1961 , and that death occurred at 11:40 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Clay E. Durrett				22b. DATE 11/14/61				22c. PHYSICIAN'S NAME (Type) Dr. Clay E. Durrett, M.D.			
22d. ADDRESS 236 Virginia Ave., Cumberland, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22f. DATE 11/14/61			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 14, 1961				23c. NAME OF CEMETERY OR CREMATORY Camp Ground Cemetery			
23d. LOCATION (City, town or county) Near Tunnelton, W. Va.				23e. (State) MD				23f. (Country) USA			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarielli, Cumberland, Md.				24a. ADDRESS Cumberland, Md.				24b. REC'D BY REGISTRAR NOV 14 '61			
24c. REGISTRAR'S SIGNATURE Arthur S. Kraus				24d. DATE NOV 14 '61				24e. REGISTRAR'S SIGNATURE Arthur S. Kraus			



1
FOR STATE
HEALTH DEPT.

TO CITY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the County Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

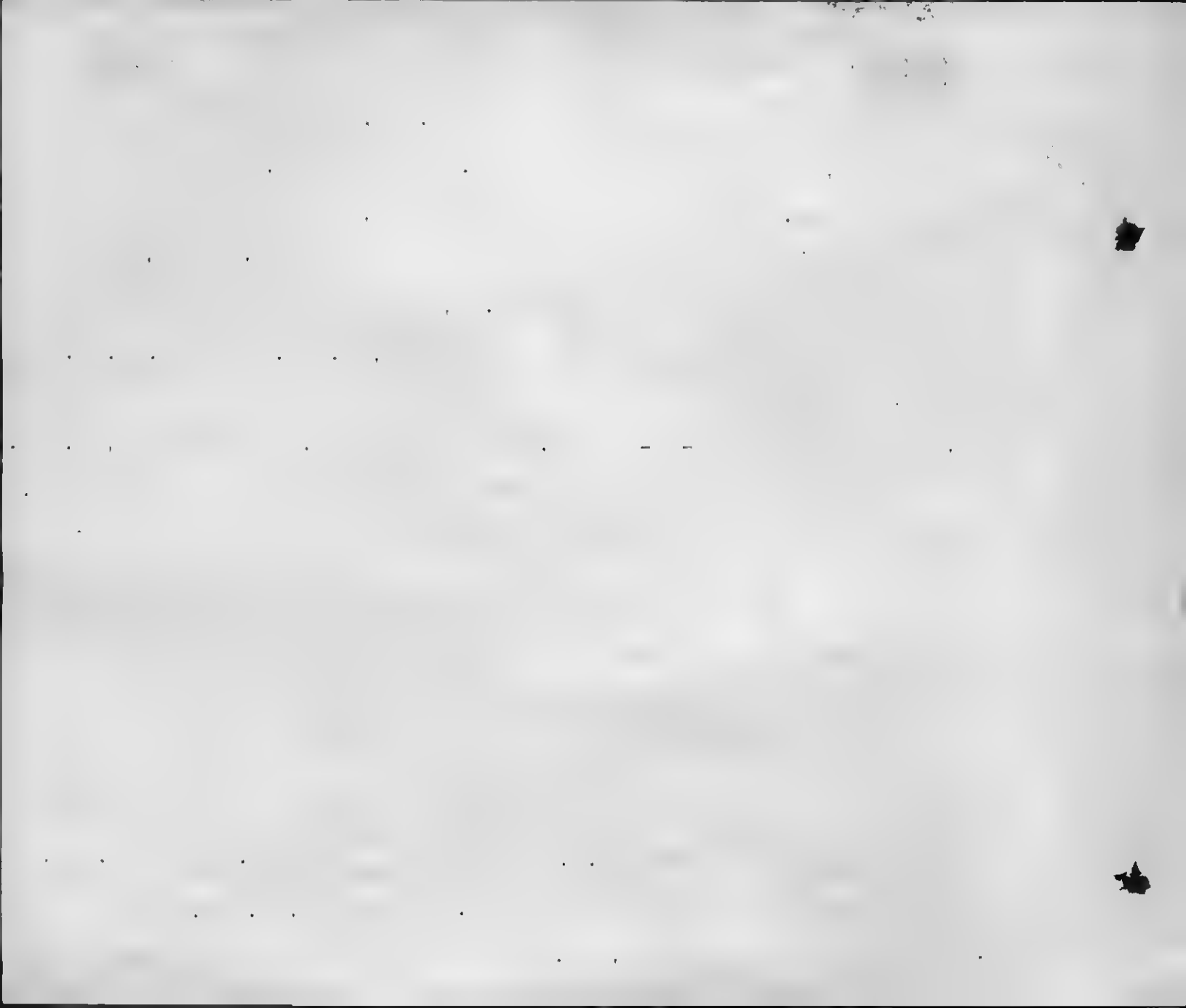
VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12075 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12062											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Mineral</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rt. # 1 Ridgeley,</u> d. STREET ADDRESS <u>Short Gap,</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland,</u>						c. LENGTH OF STAY IN 1b					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hosp.</u>						e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Nennie</u> <u>Effie</u> <u>Culp</u>						4. DATE OF DEATH <u>Nov.</u> <u>1,</u> <u>19</u> <u>61</u>					
5. SEX <u>Female</u>						6. COLOR OR RACE <u>White</u>					
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <u>Aug. 8, 1880</u> <u>81</u> yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>Farm owner</u>					
11. BIRTHPLACE (State or foreign country) <u>Greenland, W. Va.</u>						12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Charles Tucker</u>						14. MOTHER'S MAIDEN NAME <u>Susan Schell</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No,</u>						16. SOCIAL SECURITY NO. <u>232-54-4606</u>					
17. INFORMANT <u>Mr. Dick Pownall</u>						Address <u>Rt. # 1 Ridgeley, W. Va.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO (b) <u>Coronary sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> <u>11</u> <u>61</u> Hour a.m. <u>19</u> p.m. <u>19</u>											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/> 11/1/61 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <u>Benedict Skitarelic M.D.</u> Address (Street, city, town, or county) <u>Rt. # 9 Cumb. Md.</u>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>											
22b. DATE THEREOF <u>11/4/61</u>											
22c. NAME OF CEMETERY OR CREMATORY <u>Queens Point Cem.</u>											
22d. LOCATION (City, town, or country) (State) <u>Keyser, W. Va.</u>											
23. FUNERAL DIRECTOR <u>H. Wayne George</u> <u>Cumberland, Md.</u>											
24a. REC'D BY REGISTRAR <u>DATE NOV 3 '61</u>											
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>											

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1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
12078
12063

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing c. LENGTH OF STAY IN TB MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Knapps Meadow		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing d. STREET ADDRESS Knapps Meadow e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HENRY	First J.	Middle CUTTER	Last CUTTER
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/8/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Lonaconing, MD.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown	14. MOTHER'S MAIDEN NAME Barbara Cutter	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War # 1	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Minnie Cutter, Lonaconing, MD. (WIFE)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Coronary Occlusion DUE TO (c) Coronary Sclerosis		INTERVAL BETWEEN ONSET AND DEATH Sudden 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W O Mc Lane		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W O Mc Lane M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/1961	
22c. NAME OF CEMETERY OR CREMATORY Old Coney Cemetery		22d. LOCATION (City, town, or county) Lonaconing, MD.	
23. FUNERAL DIRECTOR GEORGE EICHHORN		ADDRESS LONA CONING, MD.	
24a. REC'D BY REG. STRAR NOV 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

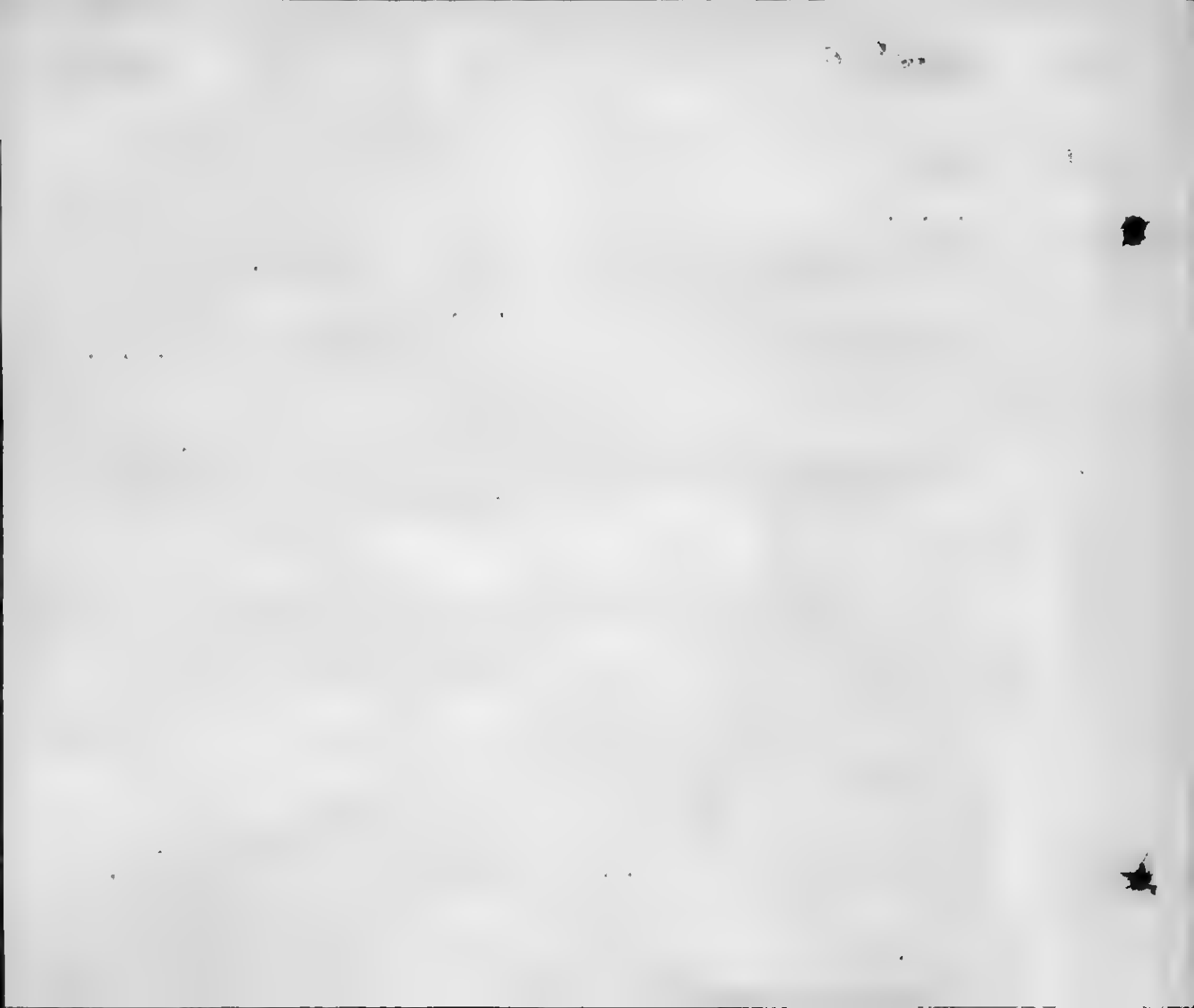
TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

(I)

MEDICAL CERTIFICATION

<div> <div> <div>1</div> <div>FOR STATE HEALTH DEPT.</div> </div> <div> <div> <div>12077</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div> <div>12064</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> </div> </div> </div> </div>									
1. PLACE OF DEATH a. COUNTY BEDFORD <i>Allegheny</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE PENNSYLVANIA b. COUNTY BEDFORD				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYNDMAN <i>Cumberland</i>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HYNDMAN*near Cumberland, Maryland				
c. LENGTH OF STAY IN 15 LIFETIME					d. STREET ADDRESS Cumberland, Maryland				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D. O. A. Memorial Hospital					a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) DENNIS LEE DARROW					4. DATE OF DEATH Month Nov. Day 11 Year 19 61				
5. SEX Male					6. COLOR OR RACE White				
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Sept. 27, 1961				
9. AGE (In years last birthday) 1 yrs.					10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland					12. CITIZEN OF WHAT COUNTRY? U. S. A.				
13. FATHER'S NAME DALE DARROW					14. MOTHER'S MAIDEN NAME NANCY MOWRY				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. (If yes, give number or date of service) HOSPITAL				
17. INFORMANT Cumberland, Maryland					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, Bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH Several Days				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part I. of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
DATE SIGNED NOVEMBER 11, 1961					Address (Street, city, town, or country) Cumberland, Md.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					22b. DATE THEREOF 11/14/61				
22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park					22d. LOCATION (City, town, or country) (State) Frostburg, Maryland				
23. FUNERAL DIRECTOR John J. Hafer					24a. REC'D BY REGISTRAR NOV 16 '61				
24b. REGISTRAR'S SIGNATURE <i>William S. Hafer</i>									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12078

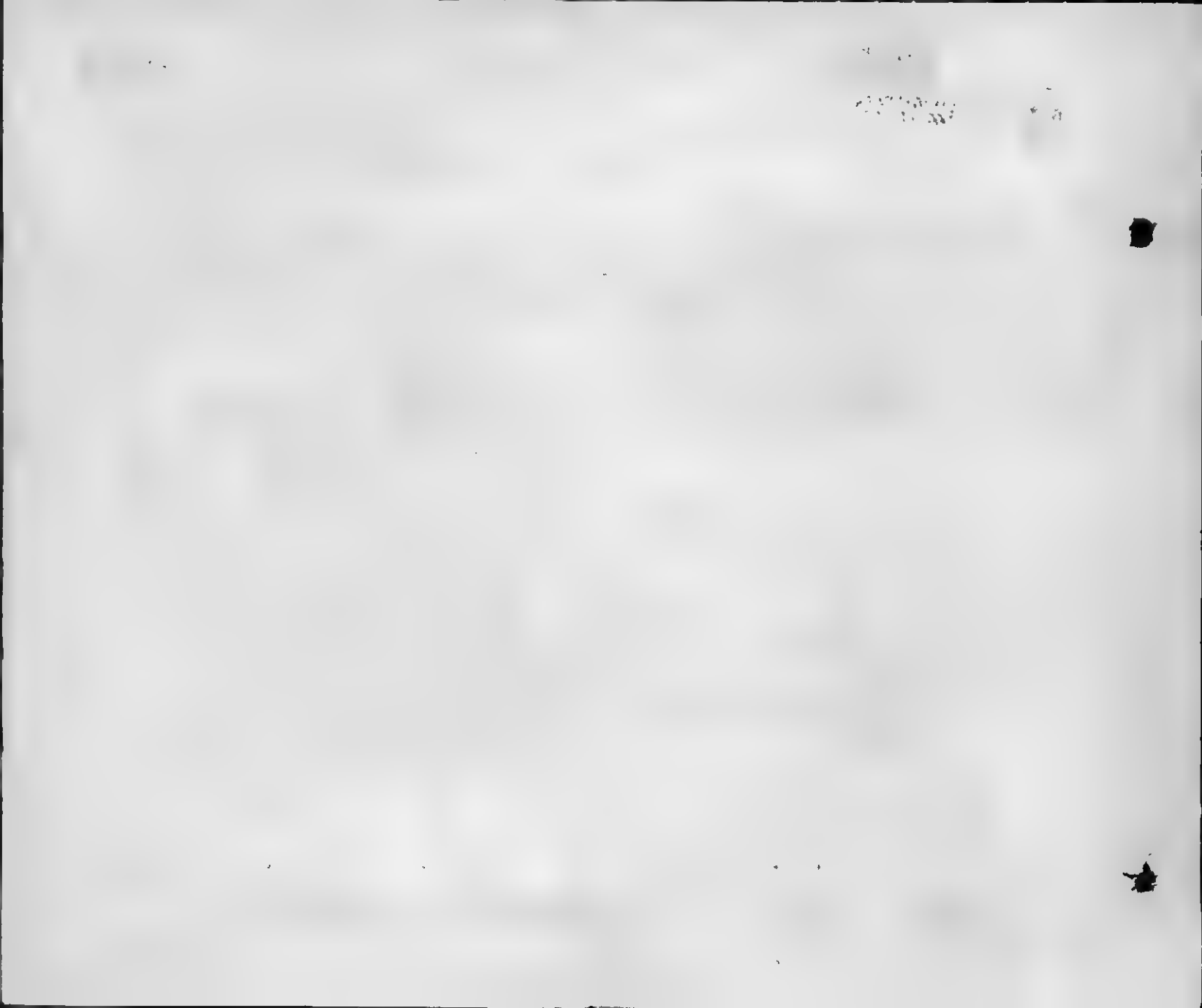
12065

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 15 4 Weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 715 MARYLAND AVENUE		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) e. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG, d. STREET ADDRESS 20 WASHINGTON ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY T. DAVIS		4. DATE OF DEATH NOVEMBER 2, 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 3RD, 1874
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Housework	9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR: Months 2 Days 19 Hours 61 Min.
11. BIRTHPLACE (County & State, or foreign country) GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PHILLIP THOMAS		14. MOTHER'S MAIDEN NAME MAGDELENA WEISENHEIMER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. JOHN C. DAVIS, WASHINGTON ST., F.B.G. MD.	
17. INFORMANT Address		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (e) Acute Cardiac failure 420.1 DUE TO Coronary occlusion Arteriosclerosis DUE TO Arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Had vagal repair 3 1/2 wks before	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. TIME OF INJURY Hour e.m. p.m. 19	
20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 115 S. CENTRE ST., CUMBERLAND, MD.	
20d. (City or town) FROSTBURG,		20e. (County) ALLEGANY	
20f. (State) MD.		21. I certify that (I) (the hospital) attended the deceased from Oct 4, 1961 to Nov 2, 1961 , that (I) (we) last saw the deceased alive on Nov 2, 1961 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.	
22a. SIGNATURE A. J. MIRKIN, M. D.		22b. DATE SIGNED 11-5-61	
22c. PHYSICIAN'S NAME (Type) A. J. MIRKIN, M. D.		22d. ADDRESS 115 S. CENTRE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) BURIAL 11-5-61		23c. NAME OF CEMETERY OR CREMATORY ZION CHURCH CEMETERY	
23d. LOCATION (City, town or county) FROSTBURG,		23e. (State) MD.	
24. FUNERAL DIRECTOR'S SIGNATURE J. R. Burt		25a. REC'D BY REGISTRAR DATE NOV 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



FOR STATE
HEALTH DEPT.

TO IN COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

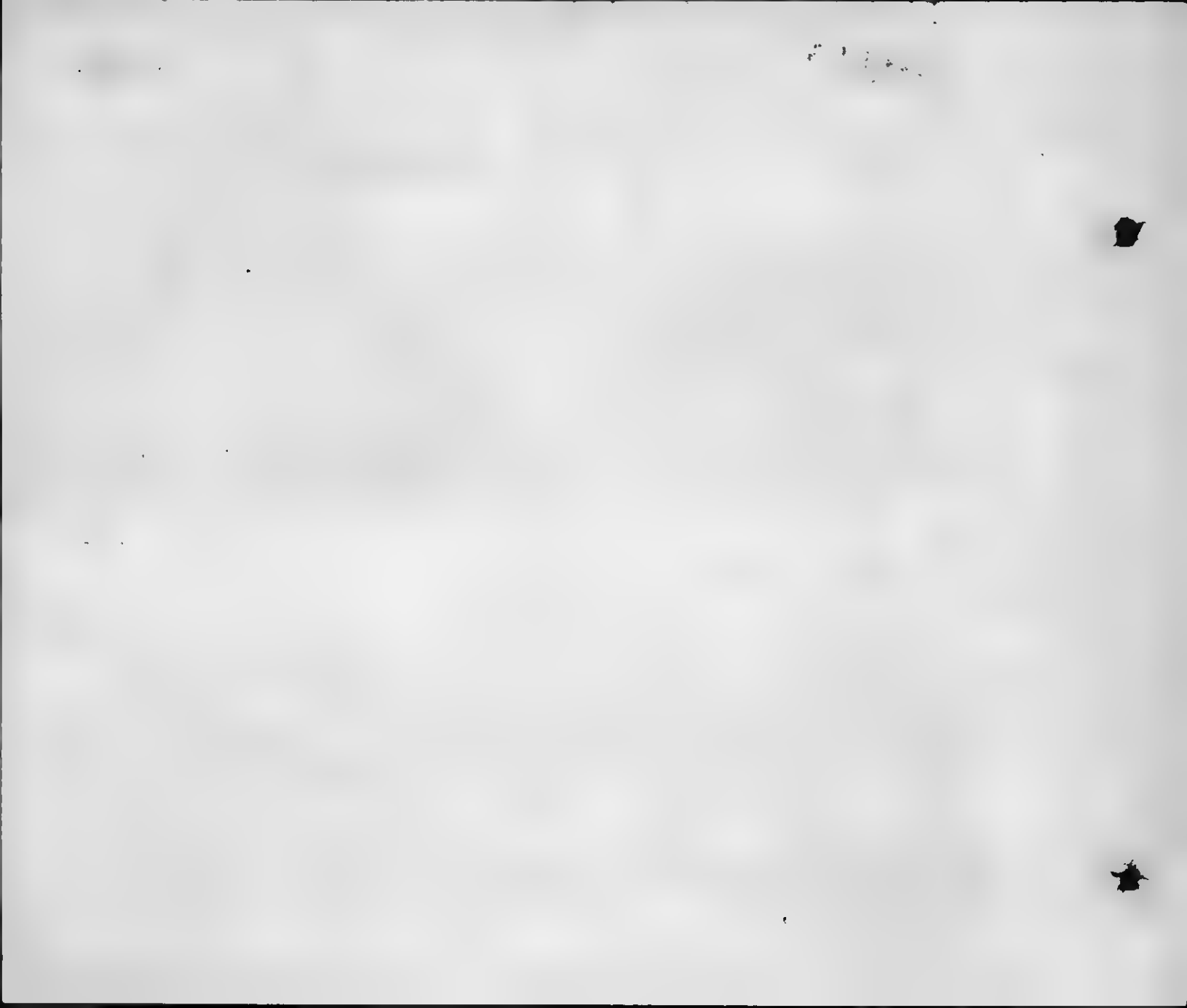
VS. A15ME
5M 9/60

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) DOA MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 523 PEARRE AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELLEN MAY DEETZ	4. DATE OF DEATH NOV. 29 19 61	5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH SEP. 20, 1881	9. AGE (In years last birthday) 80 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME 11. BIRTHPLACE (State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME PETER BRANT	14. MOTHER'S M A D E N NAME LAURA STEIN	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give year or dates of service) NONE	
16. SOCIAL SECURITY NO. MRS. RUSSELL HOFF		17. INFORMANT CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter on y one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO CORONARY OCCLUSION Condition(s), if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO CORONARY SCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERM NA. DISEASE CONDITION GIVEN IN PART I (ie) SUDDEN		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.		DATE SIGNED November 29, 1961 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF DEC. 2, 1961	22c. NAME OF CEMETERY OR CREMATORY ZION MEMORIAL BURIAL PARK 22d. LOCATION (City, town, or county) (State) CUMBERLAND, MD.	
23. FUNERAL DIRECTOR BYRON KIGHT ADDRESS CUMBERLAND, MD.		24a. REC'D BY REGISTRAR NOV 30 '61 24b. REGISTRAR'S SIGNATURE Charles S. Thomas	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12080

Item 2 Film 301-11-20/61-104

12067

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> c. LENGTH OF STAY IN TB <u>1 Day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Miners Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> d. STREET ADDRESS <u>3400 University Place</u>	
3. NAME OF DECEASED (Type or print) First <u>Ralph</u> Middle <u>C.</u> Last <u>Downey</u> 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>August 11th, 1903</u> 9. AGE (In years last birthday) <u>58 yrs.</u> IF UNDER 1 YEAR: Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min. <u>4</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Master Chemist</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Davison Chem. Co.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William W. Downey</u>		14. MOTHER'S MAIDEN NAME <u>Mayme Hoffman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>213-20-4058</u>		17. INFORMANT <u>Joseph Downey, Frostburg, Md.</u> Address <u>Barnard Place,</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO (b) <u>Chronic bronchitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>		20c. TIME OF INJURY Month, Day, Year <u>11-9-1961</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u></u> 20f. (City or town) (County) (State) <u>Frostburg, Md.</u>	
21. I certify that (I) (the hospital) attended the deceased from <u>11-9-1961</u> to <u>11-10-1961</u> , that (I) (we) last saw the deceased alive on <u>11-10-1961</u> , and that death occurred at <u>12:23 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>H.C. Diehl</u> M.D. <u>H.C. Diehl, M.D.</u>		22b. DATE SIGNED <u>11/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>H.C. Diehl, M.D.</u>		22d. ADDRESS <u>FROSTBURG, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-13-61</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst</u>		25a. REC'D BY REGISTRAR <u>NOV 13 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Frostburg, Md.</u>	



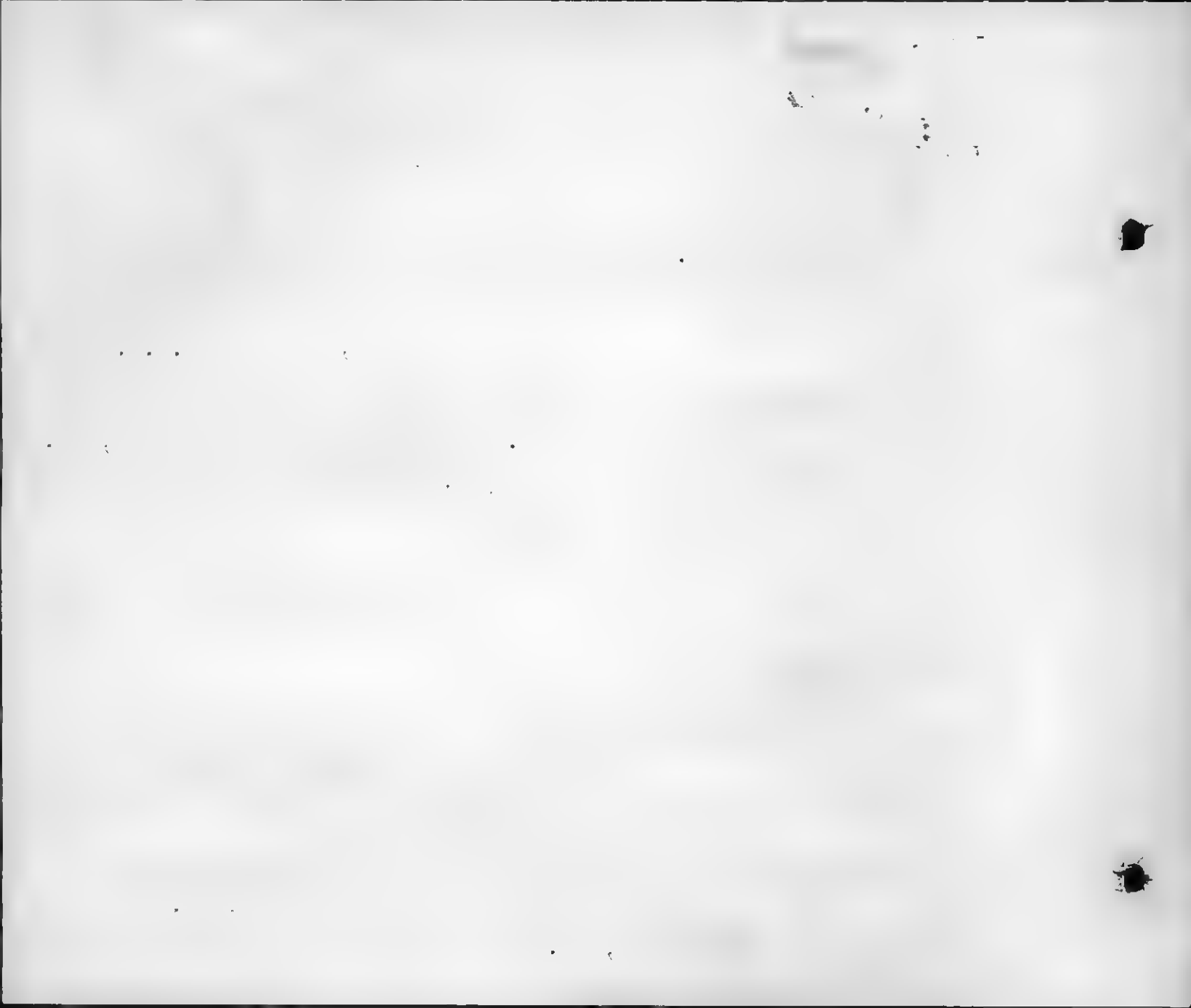
may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12081

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12068

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Knapps Meadow				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle L. Last DUCKWORTH				4. DATE OF DEATH Month 11 Day 22 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/31/1874	9. AGE (In years last birthday) 87 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) New Germany, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Israel Duckworth				14. MOTHER'S MAIDEN NAME Mary Wiland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Joseph Crawford, Lonaconing, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial ischemia 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic CV disease class III DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 36 hrs. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 2 19 56 , to Nov. 22 19 61 , that (I) (we) lost saw the deceased alive on Oct. 9 19 61 , and that death occurred at _____ M, from the causes and on the date stated above.							
22a. SIGNATURE L. R. Miles, Jr.				22b. DATE SIGNED 11-24-61		22c. PHYSICIAN'S NAME (Type) L. R. MILES, JR., M.D.	
22d. ADDRESS LONACONING, MD.				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/25/1961		23c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		23d. LOCATION (City, town, or county) (State) Lonaconing, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN				25a. REC'D BY REGISTRAR NOV 27 '61		25b. REGISTRAR'S SIGNATURE Charles E. Kline	

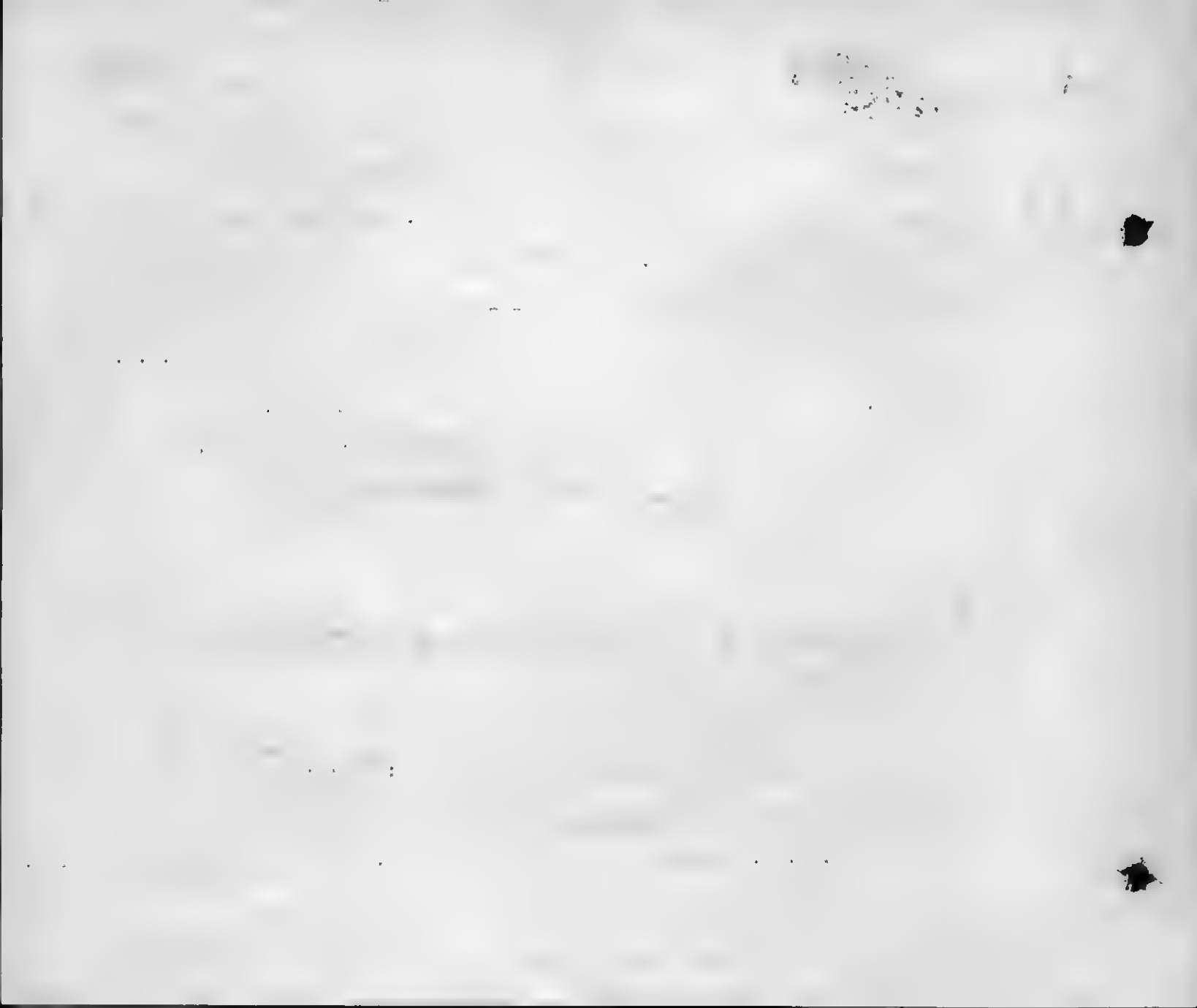


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
15M 9/60

13
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I
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12082
CERTIFICATE OF DEATH
12069

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 48 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND f. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 11 S. SMALLWOOD STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GERTRUDE L. ELLIOTT		4. DATE OF DEATH NOVEMBER 15 1961	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 10-9-1881		9. AGE (in years last birthday) 79 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE G. AHN		14. MOTHER'S MAIDEN NAME ELIZABETH FREDERICK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) Dissecting (a), stating the underlying cause last. DUE TO (c) Aortic		INTERVAL BETWEEN ONSET AND DEATH 9-28-61	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive arteriosclerotic vascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
2Dc. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-28-61 to 11-15-61 , that (I) (we) last saw the deceased alive on 11-15-61 , and that death occurred at 11:00 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Dr. W. F. Williams		22b. DATE SIGNED 11-16-61	
22c. PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 18, 1961	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Cumberland, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		25a. REC'D BY REGISTRAR NOV 20 61	
ADDRESS Cumberland, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Huns	



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MARYLAND STATE DEPARTMENT OF HEALTH

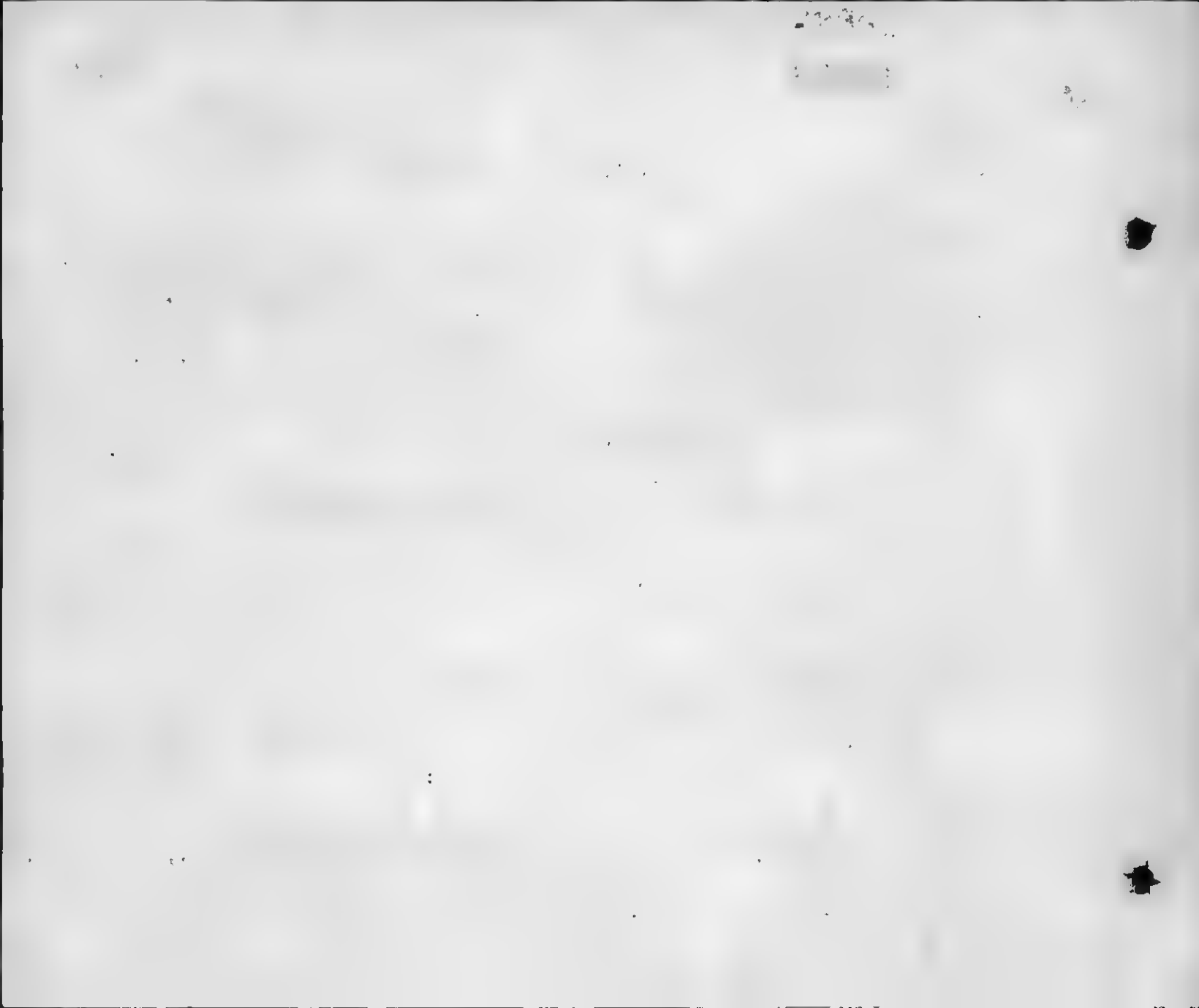
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12083

12070

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if not; last residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 37 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDLOTHIAN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last REGINA W EVANS		4. DATE OF DEATH Month Day Year NOVEMBER 16 19 61			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH MAY 20, 1907		9. AGE (In years last birthday) 54 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 54	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY RESTAURANT		11. BIRTHPLACE (Country & State, or foreign country) MARYLAND	
13. FATHER'S NAME SAMUEL WEIMER		14. MOTHER'S MAIDEN NAME DELLA CROWE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-14-6594		17. INFORMANT MEMORIAL HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Hepatic insufficiency and failure Carcinomatosis Carcinoma of the cervix		INTERVAL BETWEEN ONSET AND DEATH one week one year three years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (1) (this hospital) attended the deceased from... 1958 to 11/15, 1961, that (1) (we) last saw the deceased alive on 11/15 1961, and that death occurred at 3:30 AM from the causes and on the date stated above.					
22a. SIGNATURE Thomas F. Lewis		M.D. "		22b. DATE SIGNED NOV 20 '61	
22c. PHYSICIAN'S NAME (Type) THOMAS F. LEWIS		22d. ADDRESS WASHINGTON & CUMBERLAND ST., CUMBERLAND, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-18-61		23c. NAME OF CEMETERY OR CREMATORY F.B.G. MEMORIAL PARK	
23d. LOCATION (City, town or county) FROSTBURG,		(State) MD.			
24. FUNERAL DIRECTOR'S SIGNATURE J. P. Durat		ADDRESS FROSTBURG, MD.		25a. REC'D BY REGISTRAR NOV 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hines					



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

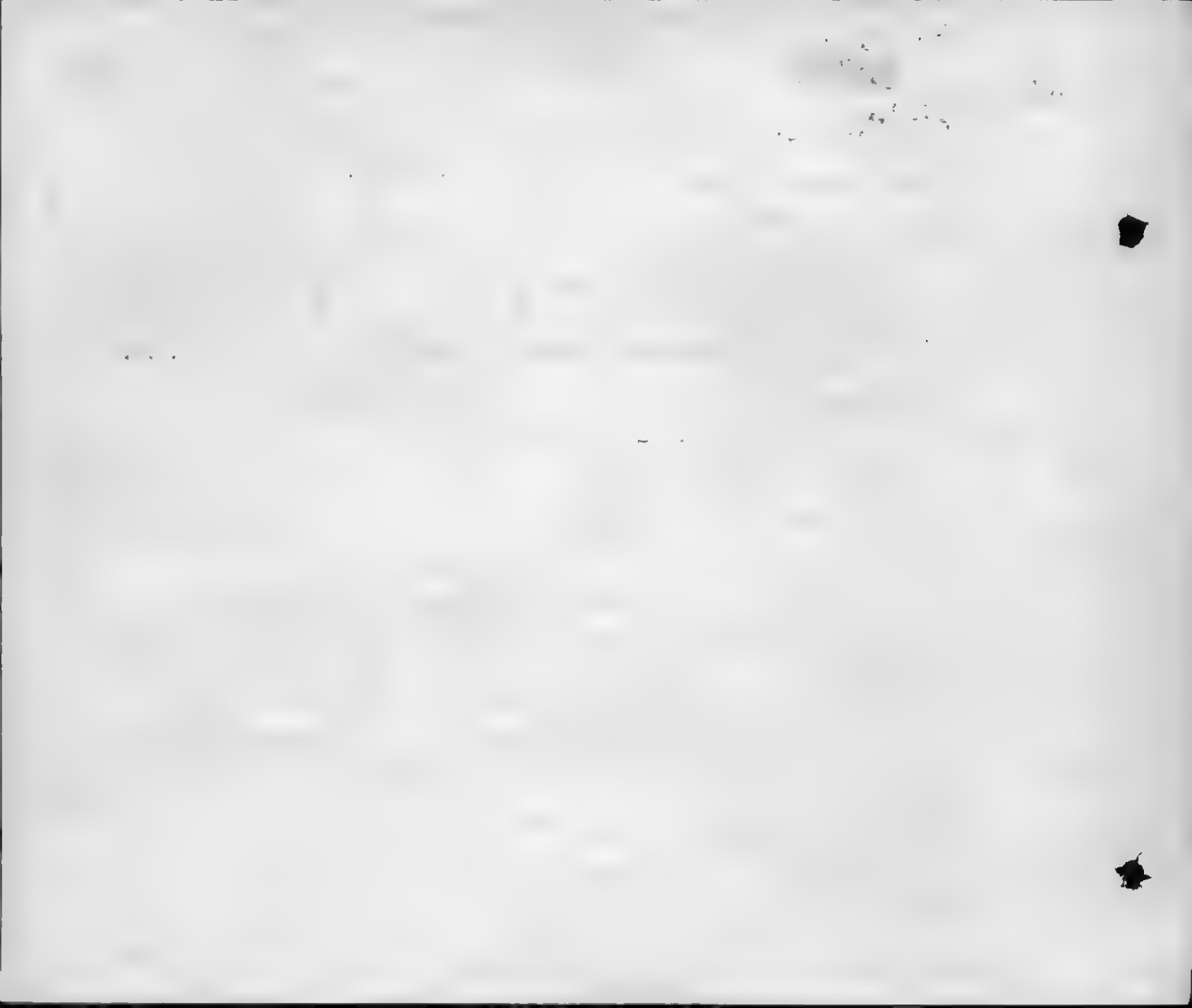
CERTIFICATE OF DEATH

12084

12071

PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY in 1b 23 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MT. SAVAGE. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last LAWRENCE A FANNON		4. DATE OF DEATH Month Day Year 11 26 19 61	
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 10/27/85 9. AGE (In years last birthday) 76 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BANK PRESIDENT 10b. KIND OF BUSINESS OR INDUSTRY FIRST NAT'L BANK 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD FANNON 14. MOTHER'S MAIDEN NAME ELLEN CUNNINGHAM		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 213-01-8004 17. INFORMANT CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral embolus 420.1 DUE TO Auricular fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH Immediate 9 years +	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a), 19. WAS AUTOPSY PERFORMED? Ruptured duodenal ulcer (surgery 11/4/61); Coronary arteriosclerosis; Uremia; Myocardial fibrosis; YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year 11/26/61 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) 10/25 19 61 to 11/26 19 61 , that (I) (we) last saw the deceased alive on 11/26 19 61 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.		21. I certify that (I) (this hospital) attended the deceased from 10/25 19 61 to 11/26 19 61 , that (I) (we) last saw the deceased alive on 11/26 19 61 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.	
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON		22b. DATE SIGNED 22d. ADDRESS 50 PERSHING STREET	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 11-29-61 23c. NAME OF CEMETERY OR CREMATORY St. Patrick's 23d. LOCATION (City, town or county) Mt. Savage - Alleg. - Md.		24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25e. REC'D BY REGISTRAR 25f. REGISTRAR'S SIGNATURE	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Smith, 57 Front Ave. Frothingham Md. 25e. REC'D BY REGISTRAR NOV 30 '61 25f. REGISTRAR'S SIGNATURE Arthur S. Kline			

MEDICAL CERTIFICATION



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12085

12072

1
FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH

a. COUNTY

Allegany

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN

Lifetime

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Cumberland

d. STREET ADDRESS

439 Grand Ave.

e. IS RESIDENCE ON A FARM?
YES ☐ NO ☒

3. NAME OF DECEASED
(Type or print)

HARRY

First

R.

FAYMAN

4. DATE OF DEATH

Month

November

Day

18.

Year

1961

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED

☒ NEVER MARRIED ☐

B. DATE OF BIRTH

Jan. 1, 1906

9. AGE (In years last birthday)

55 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Months Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Brakeman

10b. KIND OF BUSINESS OR INDUSTRY

Railroad

11. BIRTHPLACE (State or foreign country)

Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Harry R. Fayman

14. MOTHER'S MAIDEN NAME

Irene Stickle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

yes War II

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Mrs. Harry Fayman, Cumberland, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

INTRA*ABDOMINAL HEMORRHAGE

INTERVAL BETWEEN ONSET AND DEATH
HOURS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO

(b)

RUPTURE OF ARTERIOSCLEROTIC ABDOMINAL ANEURYSM

DUE TO

(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY
Hour a.m.
p.m.

Month, Day, Year
19

20d. INJURY OCCURRED
While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐

ACTUAL SIGNATURE

Benedict Skitarelic

M.D.

ASSISTANT MEDICAL EXAMINER ☐

DATE SIGNED

DEPUTY MEDICAL EXAMINER ☒ November 18, 1961

EXAMINER'S NAME (Type)

BENEDICT SKITARELIC, M.D.

Address (Street, city, town, or county)

Cumberland, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

22b. DATE THEREOF

Nov. 20, 1961

22c. NAME OF CEMETERY OR CREMATORY

Greenmount Cemetery

22d. LOCATION (City, town, or country)

Cumberland, Md.

23. FUNERAL DIRECTOR

ADDRESS

James F. Scarpelli, Cumberland, Md.

24a. REC'D BY REGISTRAR

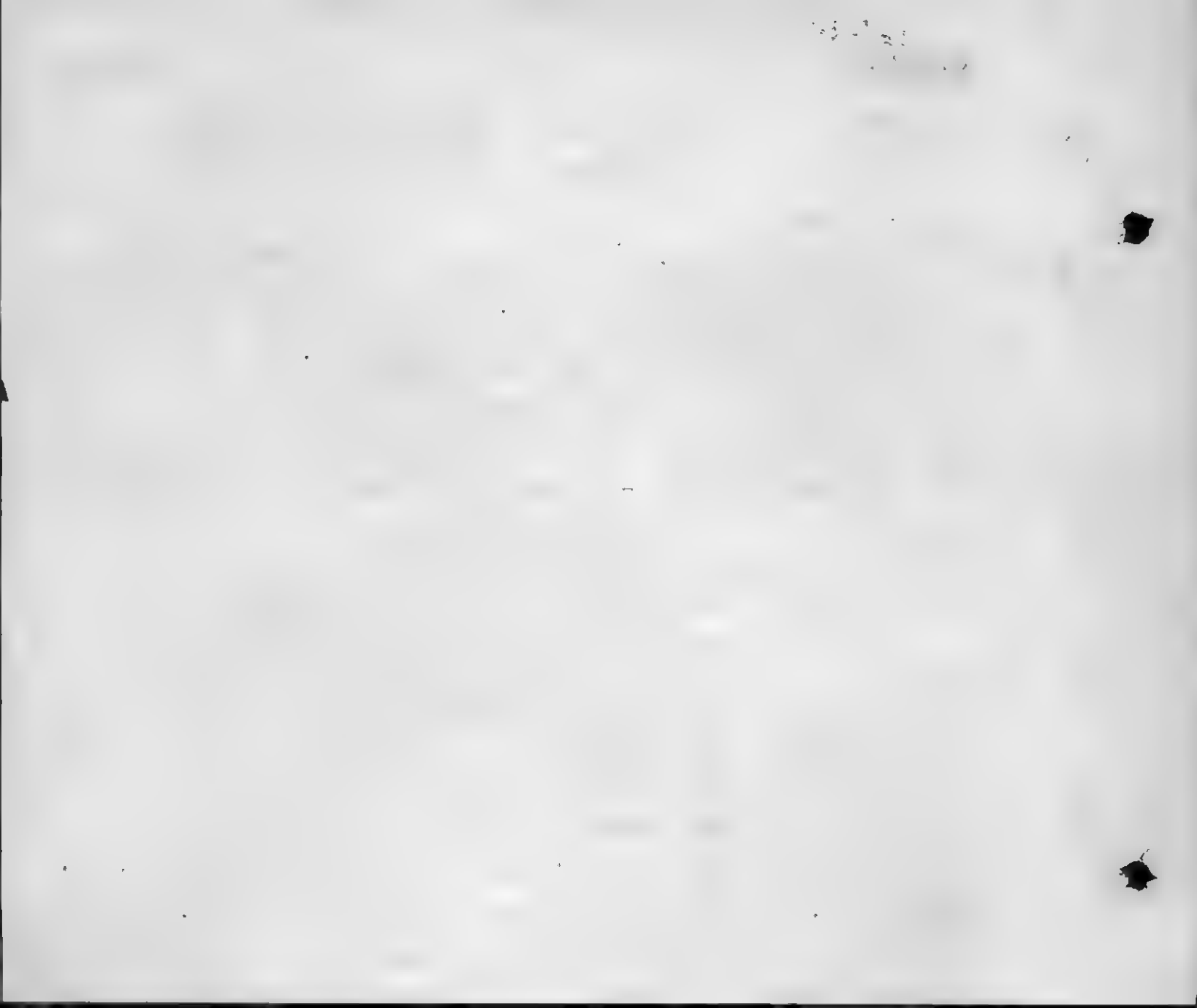
NOV 22 '61

24b. REGISTRAR'S SIGNATURE

Walter S. House

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

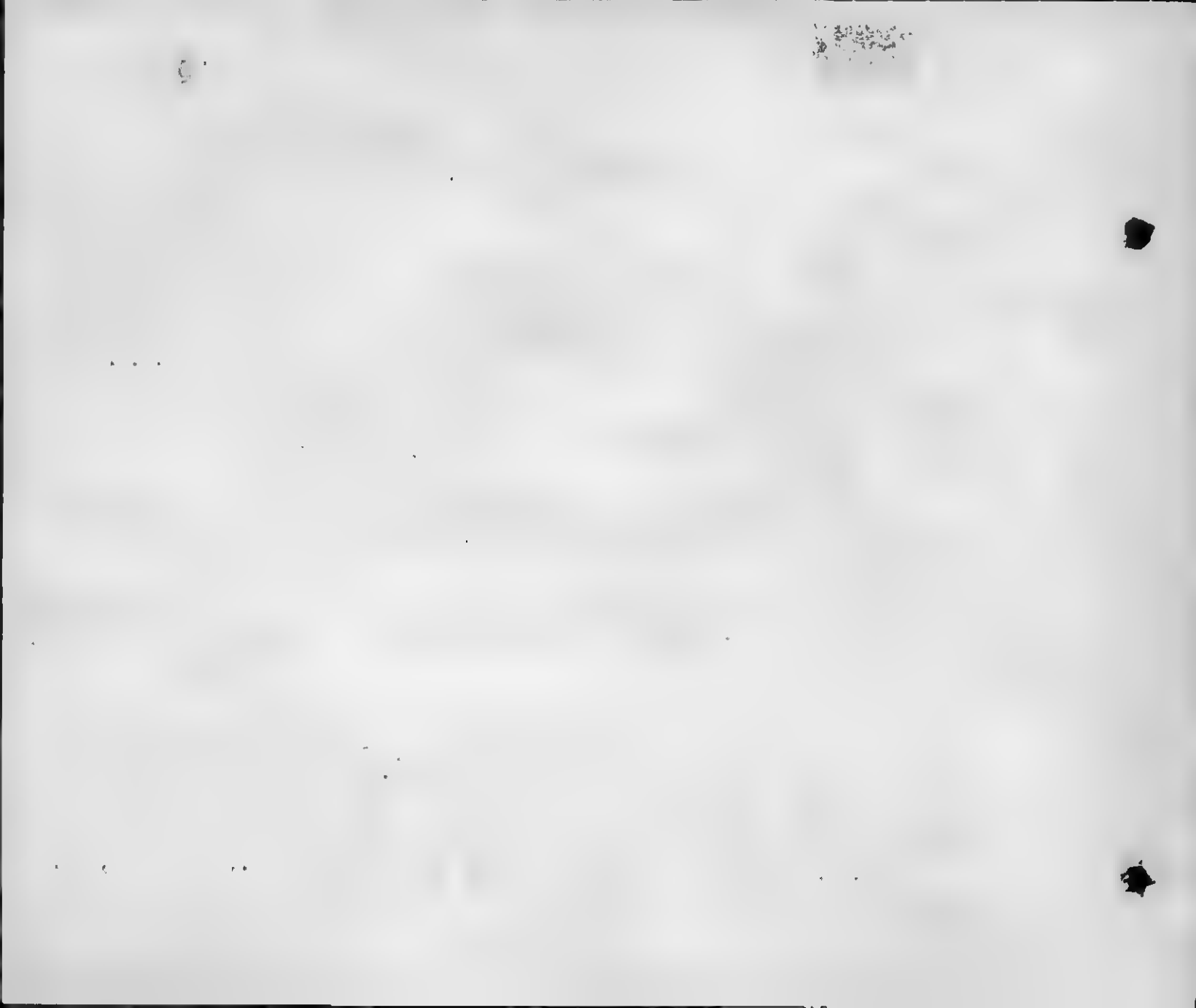
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12086

12073

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RT. # 1 RIDGELEY	
c. LENGTH OF STAY IN 1b 2 DAYS		d. STREET ADDRESS 85x	
3. NAME OF DECEASED (Type or print) SACRED HEART HOSPITAL		4. DATE OF DEATH Month 11 Day 6 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/10/81
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired RR Worker Western Md. RR		10b. KIND OF BUSINESS OR INDUSTRY MDR	
11. BIRTHPLACE (Country & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Fisher		14. MOTHER'S MAIDEN NAME Rebecca Valentine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 105-05-5609	
17. INFORMATION Carl J. Fisher, Cumb. Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute and Chronic Congestive Heart Failure with anasarca and cerebral edema DUE TO (b) Arteriosclerotic and Hypertensive CVD DUE TO (c) Obesity; age (80 yrs); cellulitis of both legs secondary to stasis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 weeks Years 0	
20a. TIME OF INJURY Hour e.m. 19 p.m.		20b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20d. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from ... November 4, 1961 to November 6, 1961 that (I) (we) last saw the deceased alive on November 6th 1961 , and that death occurred at 12:22 from the causes and on the date stated above.			
22a. SIGNATURE W. Doerner		22b. DATE SIGNED 11-7-61	
22c. PHYSICIAN'S NAME (Type) DR. W. DOERNER		22d. ADDRESS 414 North Mechanic St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/9/61	
23c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cem.		23d. LOCATION (City, town or county) (State) Cumberland Md	
24. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		25a. REC'D BY REGISTRAR NOV 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Krause			



12087

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

12074

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 2/2/1958			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irene Middle A. Last Footen				4. DATE OF DEATH Month November Day 7, Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 23-1889		9. AGE (In years lost birthday) 72 yrs	10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Frostburg, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas Footen				14. MOTHER'S MAIDEN NAME Catherine Casey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, chronic, degenerative DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mental Retardation DUE TO (c) Contractural Deformity, Lower Extremities							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/2/1958 19____, to 11/7/61 19____, that (I) (we) last saw the deceased alive on 11/6/61 @ 9:00 A.M. and her death occurred at ____ M., from the causes and on the date stated above.							
22a. SIGNATURE Dr. Lee B. Mathews		M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11/7/61			
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-9-1961		23c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery Frostburg		23d. LOCATION (City, town, or county) (State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Paul H. Winters				25a. REC'D BY REGISTRAR NOV 14 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12088

12075

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) Barton c. LENGTH OF STAY IN 1b 79 Yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Latrobe St.		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton d. STREET ADDRESS Latrobe St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Patrick Middle Henry Last Gallagher		4. DATE OF DEATH Month Nov. Day 4 Year 1961.	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1882
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min 79	IF UNDER 24 HRS Months 79 Days 79 Hours 79 Min 79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY General Store	
11. BIRTHPLACE (State or foreign country) Barton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Patrick Gallagher		14. MOTHER'S MAIDEN NAME Mary Gannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO None	
17. INFORMANT Agnes Gallagher-Barton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Carcinoma of Lungs 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH 1 Year		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1961 to Nov. 4, 1961 , that (I) (we) last saw the deceased alive on Nov. 4, 1961 , and that death occurred at 5:05 P M, from the causes and on the date stated above.			
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED Nov. 16, 1961	
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/7/61	
23c. NAME OF CEMETERY OR CREMATORY St. Gabriels Cem.		23d. LOCATION (City, town, or county) (State) Barton Md.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. 1300		25a. REC'D BY REGISTRAR NOV 8 '61	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

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10/22

10-10-10



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12089

12076

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		d. STREET ADDRESS WINCHESTER ROAD	
3. NAME OF DECEASED (Type or print) PETER HENRY GRABENSTEIN		4. DATE OF DEATH NOV 28 19 61	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-17-1889	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME JULIUS GRABENSTEIN (D)		14. MOTHER'S MAIDEN NAME MARY MARTZ (D)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-1301	
17. INFORMANT Miss Mary Grabenstein Md.		Address Rt. #5, Cumberland, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO arteriosclerotic heart disease generalized arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 3 weeks 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-1-1961 to 11-28-1961 , that (I) (we) last saw the deceased alive on 11-28-1961 , and that death occurred at 11-28-1961 , from the causes and on the date stated above.			
22a. SIGNATURE L. Brings		22b. DATE SIGNED 11-29-61	
22c. PHYSICIAN'S NAME (Type) DR. L. BRINGS		22d. ADDRESS 57 GREENE STREET CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12-1-61	
23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town or county) (State) Frostburg Maryland.	
24. FUNERAL DIRECTOR'S SIGNATURE Reuben H. Wintersant		25a. REC'D BY REGISTRAR DEC 4 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12090

Issued 8 & 7 Film 300 11/1/61 ink

Reg. Dist. No. 77

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
f. STREET ADDRESS 506 Boyd Ave.				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Hartley Last Gray				4. DATE OF DEATH Month Nov. Day 5 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1915 Jan. 3, 1914	
9. AGE (In years last birthday) 46 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		11. BIRTHPLACE (State or foreign country) Keyser, W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Winfield Scott Gray				14. MOTHER'S MAIDEN NAME Bertie Beall			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. War II		17. INFORMANT Mrs. Raymond Gray, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) --- DUE TO (c) ---							INTERVAL BETWEEN ONSET AND DEATH SUDDEN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) BENEDICT SKITARELIC?, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 5, 1961			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 8, 1961		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarnelli, Cumberland, Md.				24a. REC'D BY REGISTRAR NOV 7 '61		24b. REGISTRAR'S SIGNATURE J. S. Tuma	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12091

12078

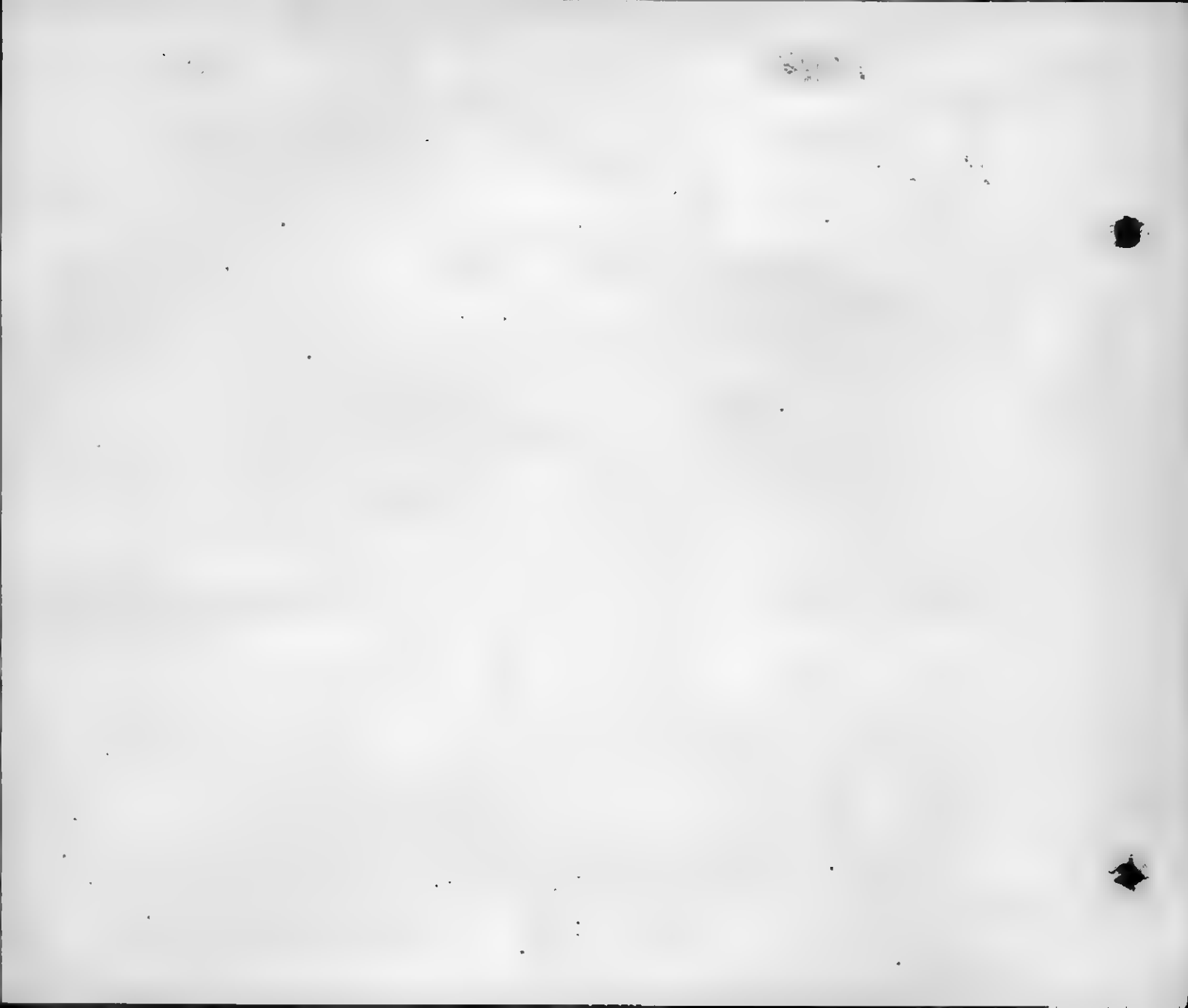
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 719 Memorial Avenue		d. STREET ADDRESS 719 Memorial Avenue	
3. NAME OF DECEASED (Type or print) First Cora Middle Ellen Last Grimm		4. DATE OF DEATH Month Nov. Day 20 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 12, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	9. AGE (In years last birthday) 86 yrs. IF UNDER 1 YEAR Months Days Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Armstrong Valley, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Warfel		14. MOTHER'S MAIDEN NAME Sarah Dietrich	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Miss Coretta Davis, Cumberland, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarct DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 Wks. 10 AM -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 9, 1961 to July 24, 1961 ; that (I) (we) last saw the deceased alive on July 24, 1961 , and that death occurred at 8 PM , from the causes and on the date stated above.			
22a. SIGNATURE H. W. Eliason M.D.		22b. DATE SIGNED May 20 1961	
22c. PHYSICIAN'S NAME (Type) Dr. H. W. Eliason		22d. ADDRESS 203 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Dec. 1, 1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DEC 4 '61	
25b. REGISTRAR'S SIGNATURE Robert S. Thomas			

30.151

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12092 CERTIFICATE OF DEATH 12079

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN It <u>40 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>617 Elm St.</u>		e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
f. STREET ADDRESS <u>617 Elm St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Juanita Mae Groves</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 1, 1921</u>
9. AGE (In years last birthday) <u>40 yrs.</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy Store</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Callie H. Burns</u>		14. MOTHER'S MAIDEN NAME <u>Ella Jones</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Vernon Groves, Cumberland, Md.</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Mitotic Carcinoma, generalized</u> <u>110X</u> DUE TO (b) <u>Carcinoma Breast</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>Nov 2</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov 1</u> , 19 <u>61</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Carlton Brinsfield</u>		22b. DATE SIGNED <u>11-5-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Carlton Brinsfield</u>		22d. ADDRESS <u>272 Baltimore Ave. Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 5, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 7 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		25c. REGISTRAR'S SIGNATURE <u> </u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12093 CERTIFICATE OF DEATH 12080											
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u> c. LENGTH OF STAY in 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>443 Henderson Ave.</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u> d. STREET ADDRESS <u>1 443 Henderson Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Anna C. Hart</u>						4. DATE OF DEATH <u>Nov. 18</u> 19 <u>61</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1986</u> yrs. <u>75</u>		9. AGE (In years last birthday) <u>75</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours M'n.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						11b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland Md.</u>					
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>						13. FATHER'S NAME <u>John M. Hart</u>					
14. MOTHER'S MAIDEN NAME <u>Christine Stark</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					
16. SOCIAL SECURITY NO. <u>—</u>						17. INFORMANT <u>Mrs Ethel C. Rambo, Washington D.C.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Myocardial Degeneration</u>											
422.1 DUE TO (b) <u>Arteriosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last, (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Pulmonary Emphysema</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/10</u> to <u>11/12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/10</u> , 19 <u>61</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Louis H. Ley Jr.</u>						22b. DATE SIGNED <u>11/20/61</u>		22c. PHYSICIAN'S NAME (Type) <u>LED N. LEY JR</u>		22d. ADDRESS <u>476 N. Centre St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/20/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Md.</u>		25a. REC'D BY REGISTRAR <u>DATE NOV 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

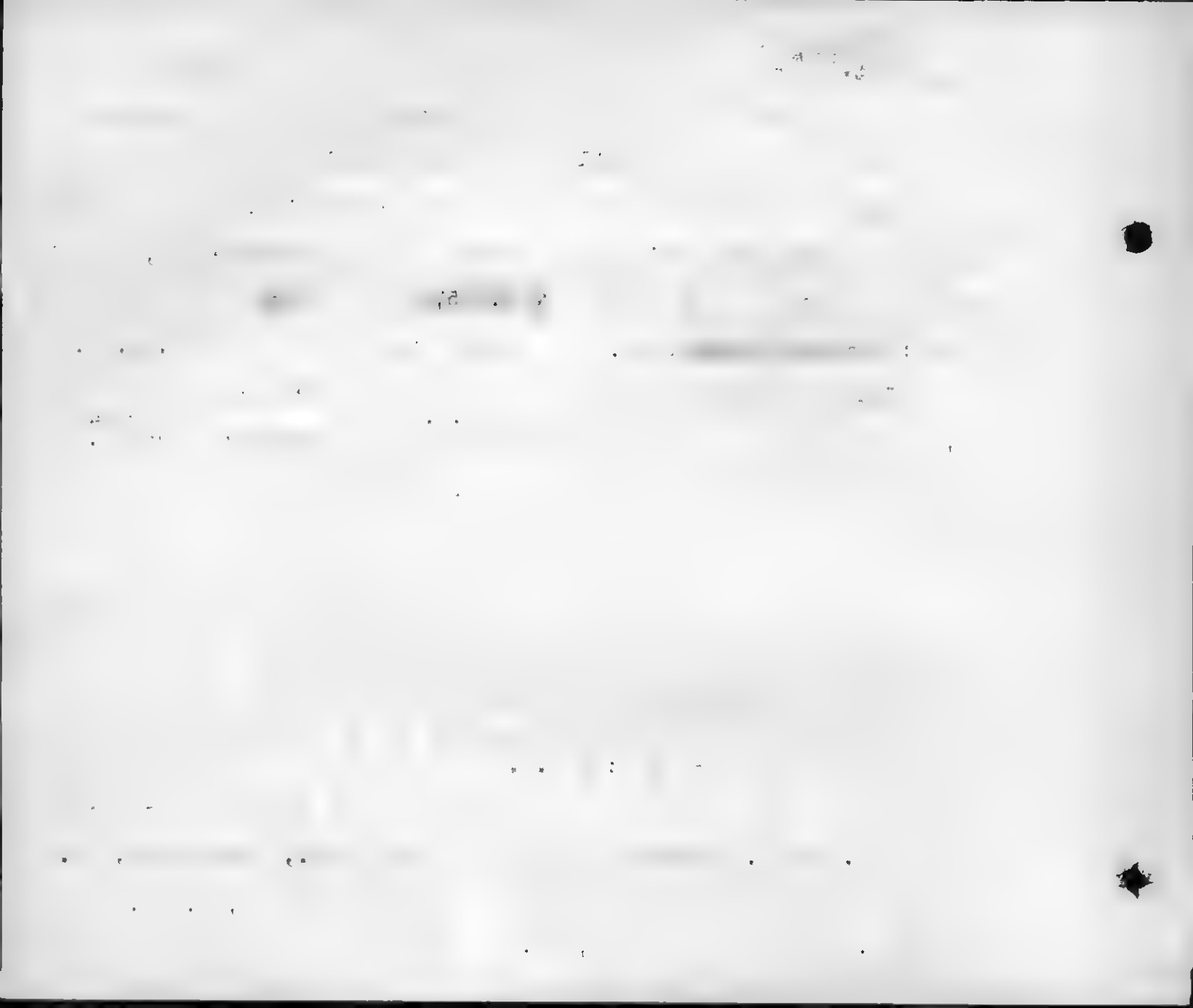
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12094

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12081

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 7/14/1961			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Charles William Heath				4. DATE OF DEATH Month Day Year November 4, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1869	
9. AGE (in years last birthday) 92 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Dispatcher Bus Co.				10b. KIND OF BUSINESS OR INDUSTRY West Virginia			
13. FATHER'S NAME Jonathan Heath				14. MOTHER'S MAIDEN NAME Mary Susan Orndorf			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.				16. SOCIAL SECURITY NO None			
17. INFORMANT P.O. Box 599				Address Cumberland Allegany County Infirmary Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, degenerative, Senile - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/14/61 19 to 11/4/61 19, that (I) (we) last saw the deceased alive on 11/3/61 19 and that death occurred at 5:30 A.M. M, from the causes and on the date stated above.							
22a. SIGNATURE R. B. Mathews				22b. DATE SIGNED 11/4/1961		22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews	
22d. ADDRESS 49 Greene St., Cumberland, Md.				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/6/61		23c. NAME OF CEMETERY OR CREMATORY Mount Olivet		23d. LOCATION (City, town, or county) (State) Moorefield, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 7 '61	
25b. REGISTRAR'S SIGNATURE Lee B. Mathews							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

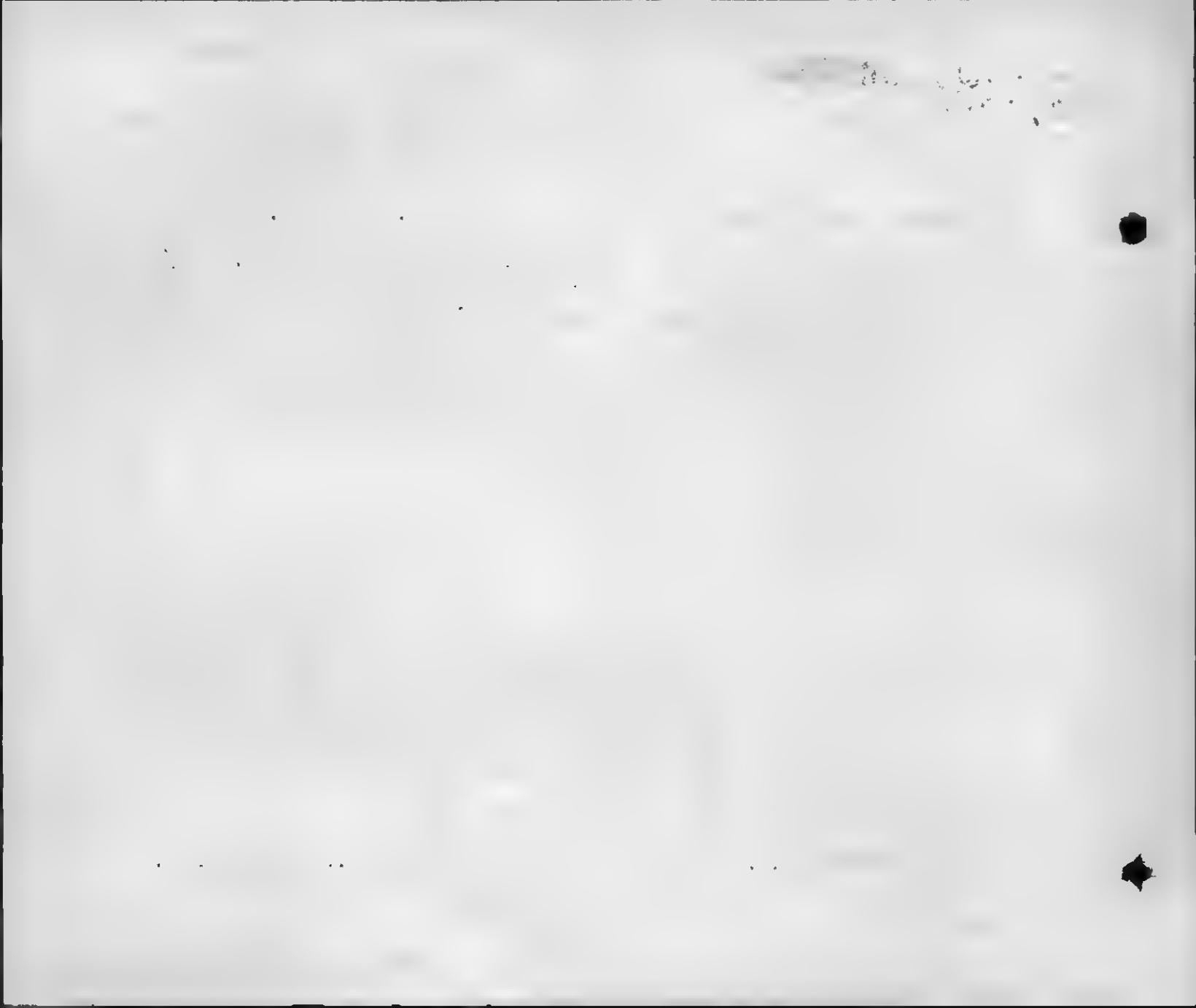
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12093

12082

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 107 S. GEORGE ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) BOYD V. HILLIARD		4. DATE OF DEATH Month NOV. Day 5 Year 1961		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 9, 1907		9. AGE (In years last birthday) 54 yrs. IF UNDER 1 YEAR: Months 5 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER				10b. KIND OF BUSINESS OR INDUSTRY DRY CLEANERS				11. BIRTHPLACE (County & State, or foreign country) VIRGINIA				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ROSSER HILLIARD				14. MOTHER'S MAIDEN NAME HATTIE VANCE				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO 16. SOCIAL SECURITY NO. 214-05-7546 17. INFORMANT PATIENT'S CHART Address _____					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) apoplectic stroke 354X DUE TO (b) extremities Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a): _____												INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) _____		20f. (City or town) _____ (County) _____ (State) _____					
21. I certify that (I) (this hospital) attended the deceased from 11-2- 1961 , to 11-5- 1961 , that (I) (we) last saw the deceased alive on 11-4- 1961 , and that death occurred at _____ M. from the causes and on the date stated above.													
22a. SIGNATURE Lewis Brings, M.D.				22b. DATE SIGNED 11-6-61		22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.		22d. ADDRESS GREENE ST., CUMBERLAND, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF NOV. 7, 1961		23c. NAME OF CEMETERY OR CREMATORY MT. HEBRON CEMETERY				23d. LOCATION (City, town or county) WINCHESTER, VA. (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT				25a. REC'D BY REGISTRAR DATE NOV 8 '61				25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>					



1
FOR STATE
HEALTH DEPT.

TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

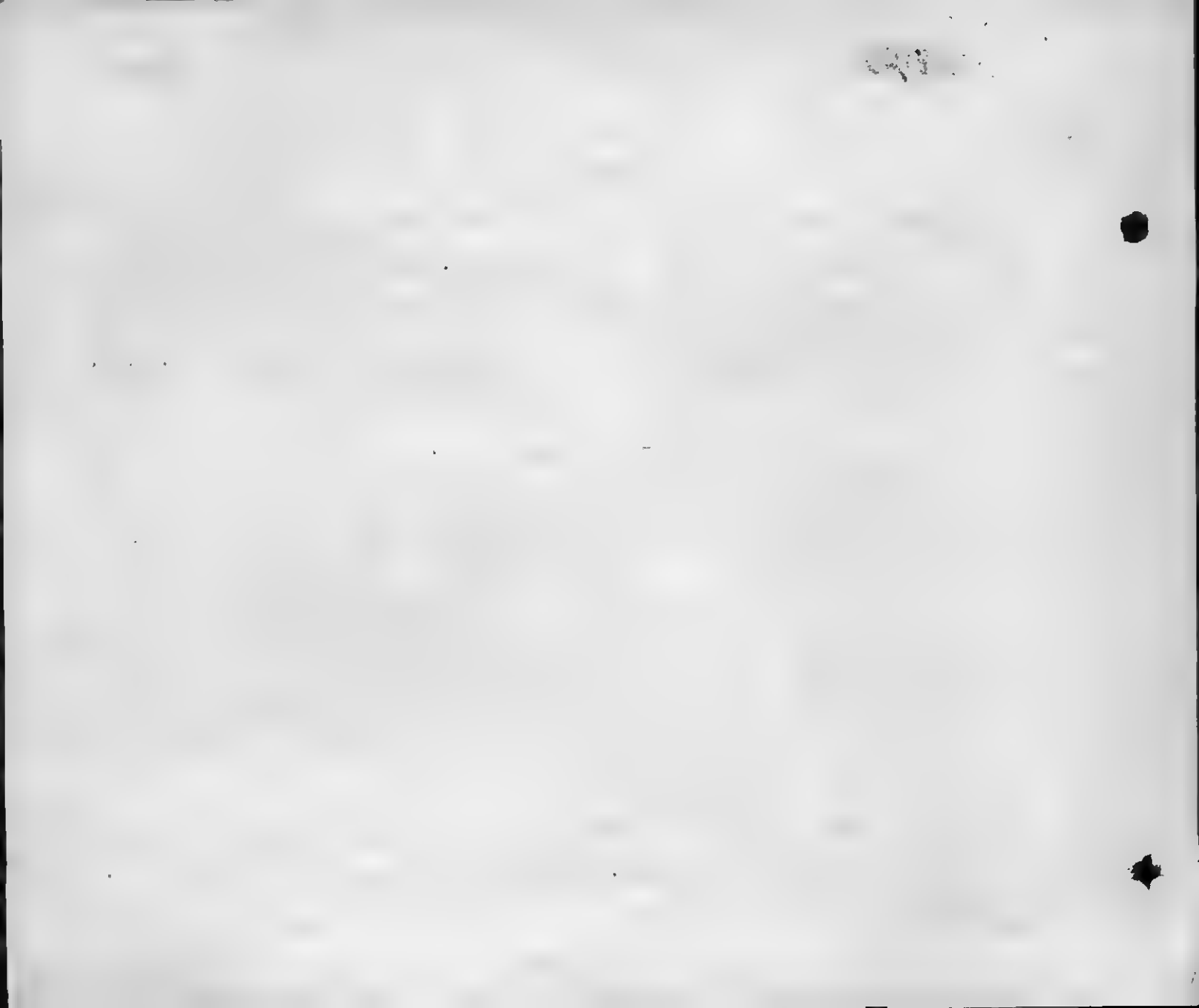
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12096

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12083

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
c. LENGTH OF STAY IN TB <u>8 Years</u>				d. STREET ADDRESS <u>103 Independence Street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Clarence Earl Hook Sr.</u>				4. DATE OF DEATH <u>November 23 19 61</u>			
5. SEX <u>Male</u>				6. COLOR OR RACE <u>White</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH <u>May 15 1900</u>			
9. AGE (In years last birthday) <u>61</u> yrs.				10. IF UNDER 1 YEAR: Months <u>1</u> Days <u>15</u> Hours <u>15</u> Min. <u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired B&O R R Fireman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Hook</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Warnick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>705-09-3450</u>			
17. INFORMANT <u>Clarence E. Hook Jr.</u>				Address <u>Cumberland Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>CORONARY OCCLUSION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY SCLEROSIS</u> (c) <u>SUDDEN</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>1</u> p.m. <u>15</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <u>Benedict Skitarelic</u>				DATE SIGNED <u>November 23, 1961</u>			
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				Address (Street, city, town, or county) <u>Cumberland, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>11/26/61</u>			
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>				22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>			
23. FUNERAL DIRECTOR <u>Ruth E. Silcox</u>				24a. REC'D BY REG. STRAR <u>NOV 27 '61</u>			
ADDRESS <u>Cumberland Maryland</u>				24b. REGISTRAR'S SIGNATURE <u>Clinton S. Kline</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12097

Reg. Div. No. 1

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			c. LENGTH OF STAY IN 1b <u>60 yrs.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>225 Grand Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Floyd</u> Middle <u>M.</u> Last <u>Hout</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 20, 1901</u>	
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. To Chief Clerk Railroad</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>Cumberland, Md.</u>		11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Henry Hout</u>	
14. MOTHER'S MAIDEN NAME <u>Naomi Harmison</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>705-05-8166</u>		17. INFORMANT Address <u>Mrs. Joseph M. Dorsey, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS WITH THROMBOSIS</u> (c) <u> </u> DUE TO (a) <u> </u> (b) <u> </u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: (a) <u> </u> (b) <u> </u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 Hr.</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>Nov. 6, 1961</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 10, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR <u>DATE NOV 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

MEDICAL CERTIFICATE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute by certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1. PLACE OF DEATH
a. COUNTY Allegany MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
c. LENGTH OF STAY IN 1b 65 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 430 Homer Street

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Allegany
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
d. STREET ADDRESS 430 Homer Street

3. NAME OF DECEASED (Type or print) Famie Elizabeth Hoyle
5. SEX Female 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ 8. DATE OF BIRTH July 9, 1896
9. AGE (In years last birthday) 65 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
11. BIRTHPLACE (County & State, or foreign country) Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John E. Squires 14. MOTHER'S MAIDEN NAME Katherine Kiffner
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. no 17. INFORMANT Mr. Howard Hoyle, Cumberland, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
60X DUE TO Coronary Artery Disease
Conditions, if any, which gave rise to immediate cause (b) Diabetes Mellitus
(a), stating the underlying cause last. (c) Immediate
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 5 yrs
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland, Md.
20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/4/55, 1955, to 11/22/61, 1961, that (I) (we) last saw the deceased alive on 11/22/61, 1961, and that death occurred at 11/22/61, from the causes and on the date stated above.
22. SIGNATURE J. F. Scarpelli M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. ADDRESS Cumberland, Md.
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery
22d. LOCATION (City, town or county) (State) Cumberland, Md.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF Nov. 25, 1961
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR NOV 28 '61
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus



TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

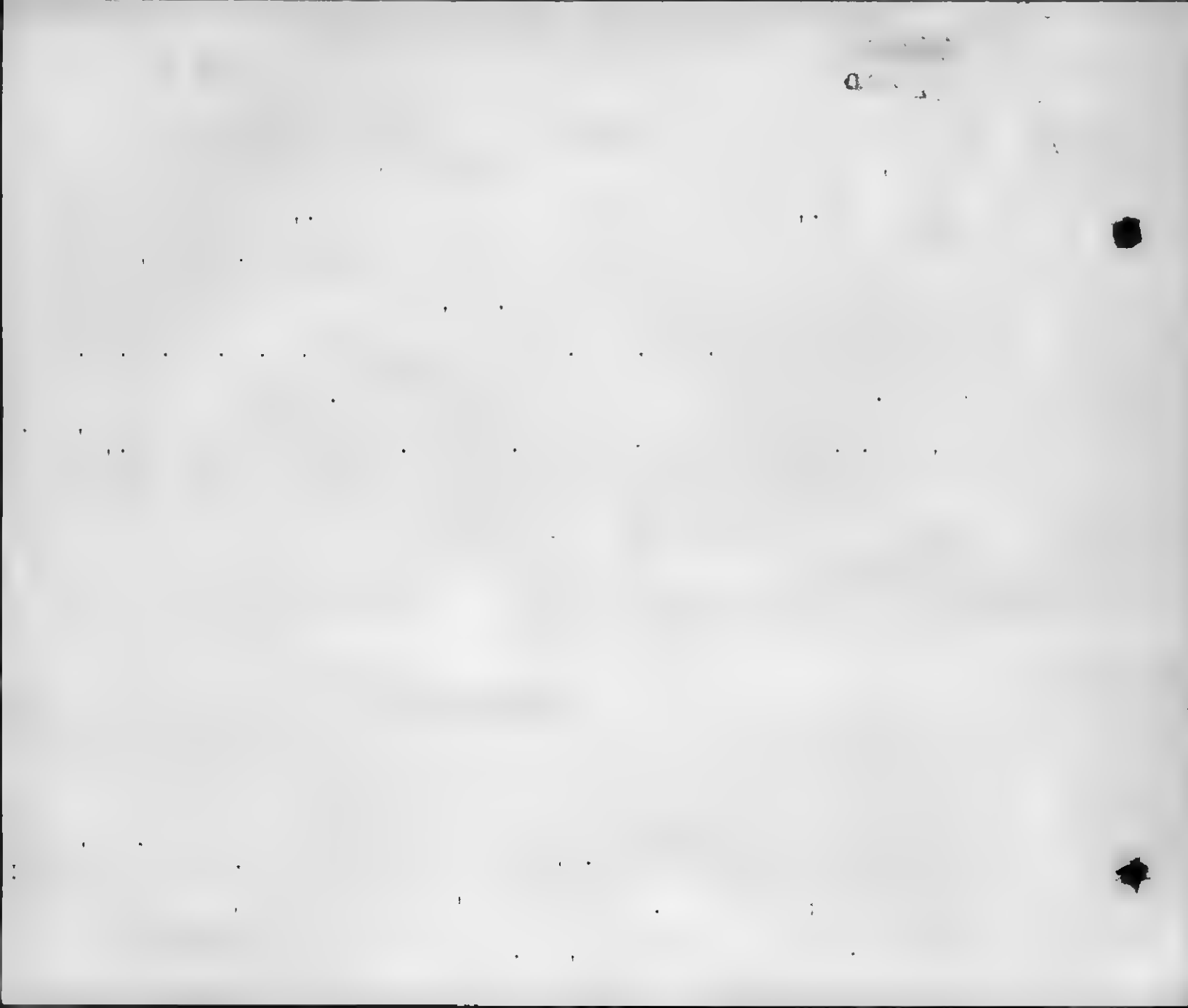
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FOR STATE
HEALTH DEPT.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1208C											
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) La Vale, c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 119 Park Ave.,				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X La Vale, d. STREET ADDRESS 119 Park Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) STATEN		First ISAAC		Middle HOYLE		Last HOYLE		4. DATE OF DEATH Month Nov. Day 9, Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1888		9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 M n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carman				10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.				11. BIRTHPLACE (State or foreign country) Berkley Springs, W.VA.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John W. Hoyle				14. MOTHER'S MAIDEN NAME Virginia M. Miller							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes, W.W.# 1				16. SOCIAL SECURITY NO. 705-05-8549				17. INFORMANT Mrs. Lucy O. Hoyle Address La Vale, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO CORONARY SCLEROSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Nov. 10, 1961			
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county) Rt. # 9 Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/61		22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul's				22d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR Charles L. George				ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE NOV 13 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



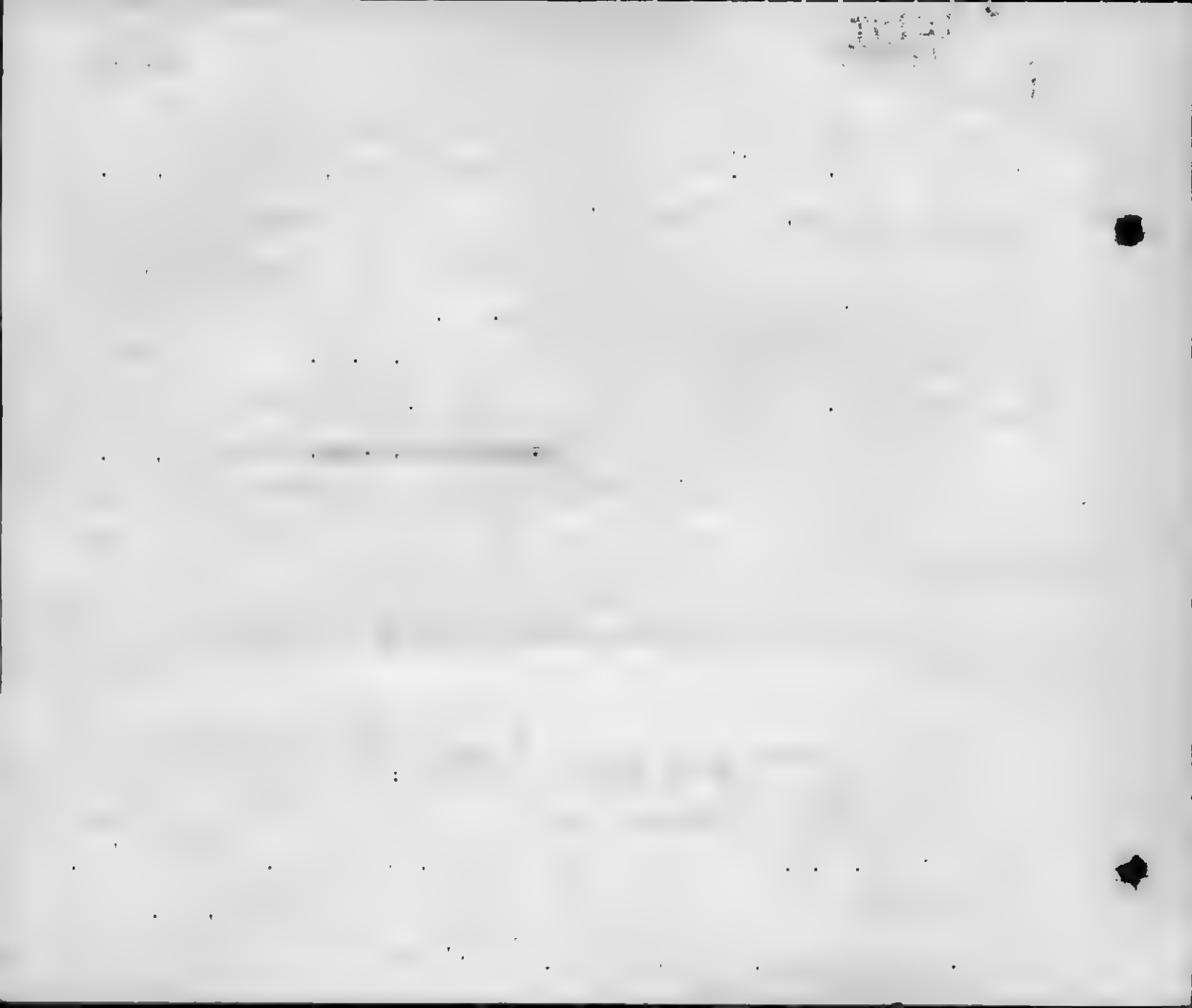
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
121006 CERTIFICATE OF DEATH 12087									
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowling Green, Cumberland Md.</u> c. LENGTH OF STAY IN 1b <u>Years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hosp tel, give street address) <u>407 Bowling Ave, Bowling Green, Cumberland</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowling Green, Cumberland, Md.</u> d. STREET ADDRESS <u>407 Bowling Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>LELA GOLDEN JONES</u>		4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>1961</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>Jan. 10, 1889</u>		9. AGE (In years last birthday) <u>72</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Grafton, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Mortimer N. Utterback</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Gelhausen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Theodore A. Jones</u> Address <u>Bowling Green, Cumberland, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of rectum</u> -IX- DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>None</u> (a), stating the underlying cause last. DUE TO (c) <u>None</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Hypertensive Arterio Sclerotic Cardiovascular</u>					INTERVAL BETWEEN ONSET AND DEATH <u>About 1 yr.</u>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (<u>no hospital</u>) attended the deceased from <u>July 6, 1960 to Nov 4, 1961</u> that (I) (<u>no</u>) last saw the deceased alive on <u>Oct 31, 1961</u> , and that death occurred at <u>5:AM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Dr. W.F. Williams</u>		22b. DATE SIGNED <u>11-4-61</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. W.F. Williams</u>		22d. ADDRESS <u>122 S. Centre St., Cumberland, Md.</u>		22e. REC'D BY REGISTRAR <u>DANOV 7 '61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/26/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George, 202 Greene St., Md.</u>					25a. ADDRESS <u>Cumberland, Md.</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

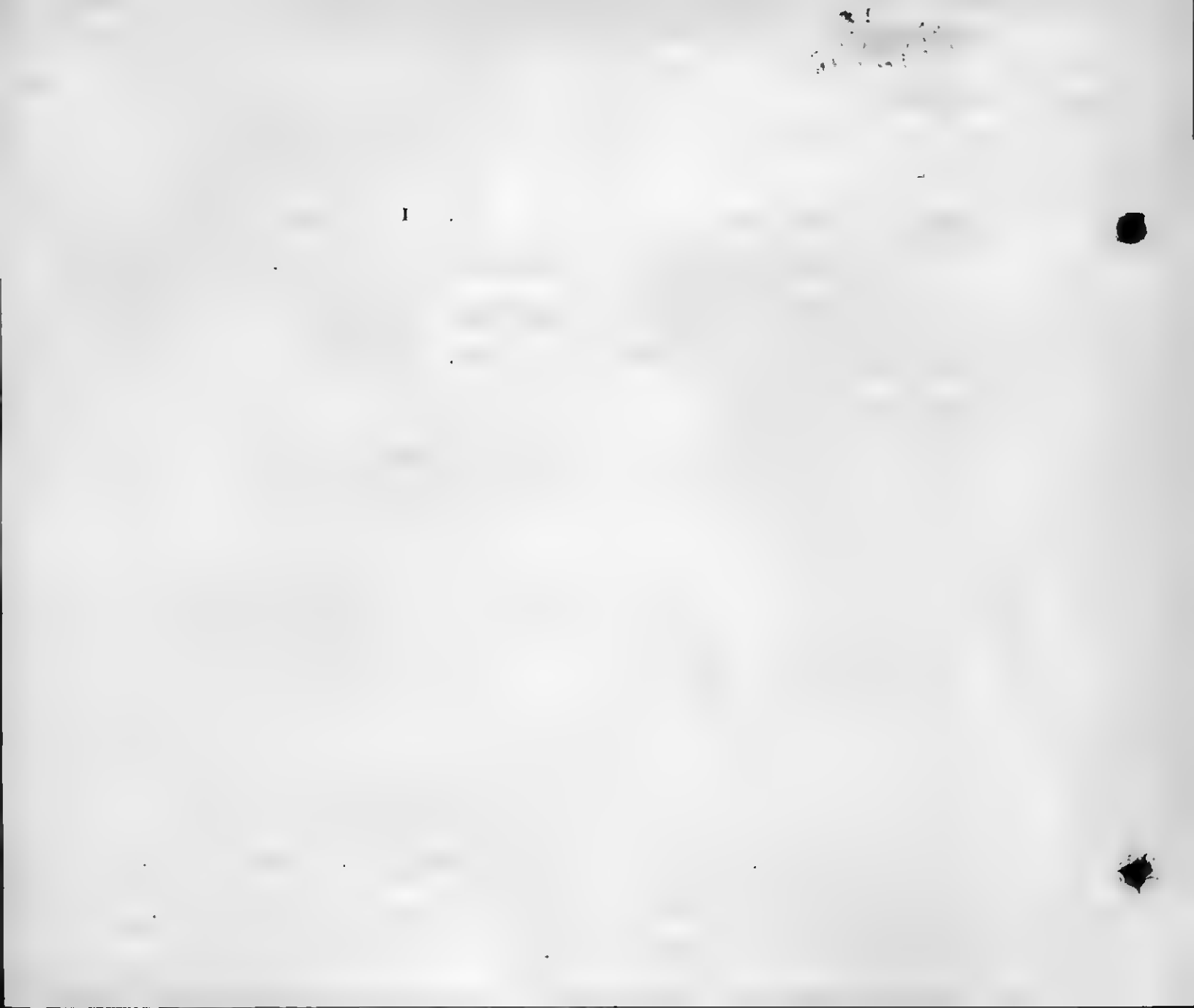
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12101

12088

1. PLACE OF DEATH a. COUNTRY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN b 44 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL--CUMBERLAND d. STREET ADDRESS RT. # 1, HOMEWOOD ADDITION e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACOB Middle WALTER Last KEARCHNER		4. DATE OF DEATH Month NOV. Day 23 Year 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 30, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (County & State, or foreign country) PENNA. FAIRHOPE
13. FATHER'S NAME JOHN KEARCHNER (DECEASED)		14. MOTHER'S MAIDEN NAME ELLEN Spaugy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. PATIENTS CHART	
17. INFORMANT Spaugy Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Cause of the esophagus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of form 18)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. 19		2Dd. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-3-1961 to 11-23-1961 , that (I) (we) last saw the deceased alive on 11-22-1961 , and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Lewis Brings		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) LEWIS BRINGS, MD.		22d. ADDRESS 57 GREENE ST., CUMBERLAND, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 26, 1961	
23c. NAME OF CEMETERY OR CREMATORY Oddfellows Cemetery		23d. LOCATION (City, town or county) (State) Flintstone, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR NOV 28 '61 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12102
CERTIFICATE OF DEATH

13089

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		e. STREET ADDRESS MT. SAVAGE	
3. NAME OF DECEASED (Type or print) First Middle Last J. ORVILLE KEFAUVER		4. DATE OF DEATH Month Day Year NOVEMBER 14, 19 61	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED		8. DATE OF BIRTH NOVEMBER 1, 1885	
9. AGE (In years; If UNDER 1 YEAR, Months; Days; Hours; Min. 76 yrs.		10. AGE (In years; If UNDER 1 YEAR, Months; Days; Hours; Min. 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher, ret.		10b. KIND OF BUSINESS OR INDUSTRY public school	
11. BIRTHPLACE (County & State, or foreign country) MIDDLETOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS F. KEFAUVER		14. MOTHER'S MAIDEN NAME JOANNA V. COOKERLY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. MEMORIAL HOSPITAL, CUMBERLAND, MD.	
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) Carcinoma of prostate	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II. of item 18.)	
20c. TIME OF INJURY Month, Day, Year 11-9-61		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 11-9-61		20f. (City or town) (County) (State) 11-15-61	
21. I certify that (I) (this hospital) attended the deceased from 11-9-61 , to 11-15-61 , that (I) (we) last saw the deceased alive on 11-9-61 , and that death occurred at 5:25 A.M. the causes and on the date stated above.		22a. SIGNATURE DR. HOWARD L. TOLSON	
22b. DATE SIGNED NOV 20 '61		22c. PHYSICIAN'S NAME (Type) DR. HOWARD L. TOLSON	
22d. ADDRESS 122 S. CENTRE STREET, CUMBERLAND, MD.		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 11/17/1961	
23c. NAME OF CEMETERY OR CREMATORY Reformed Cemetery		23d. LOCATION (City, town or county) (State) Middletown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Headhill Co.		25a. REC'D BY REGISTRAR NOV 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus		25c. REGISTRAR'S SIGNATURE	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

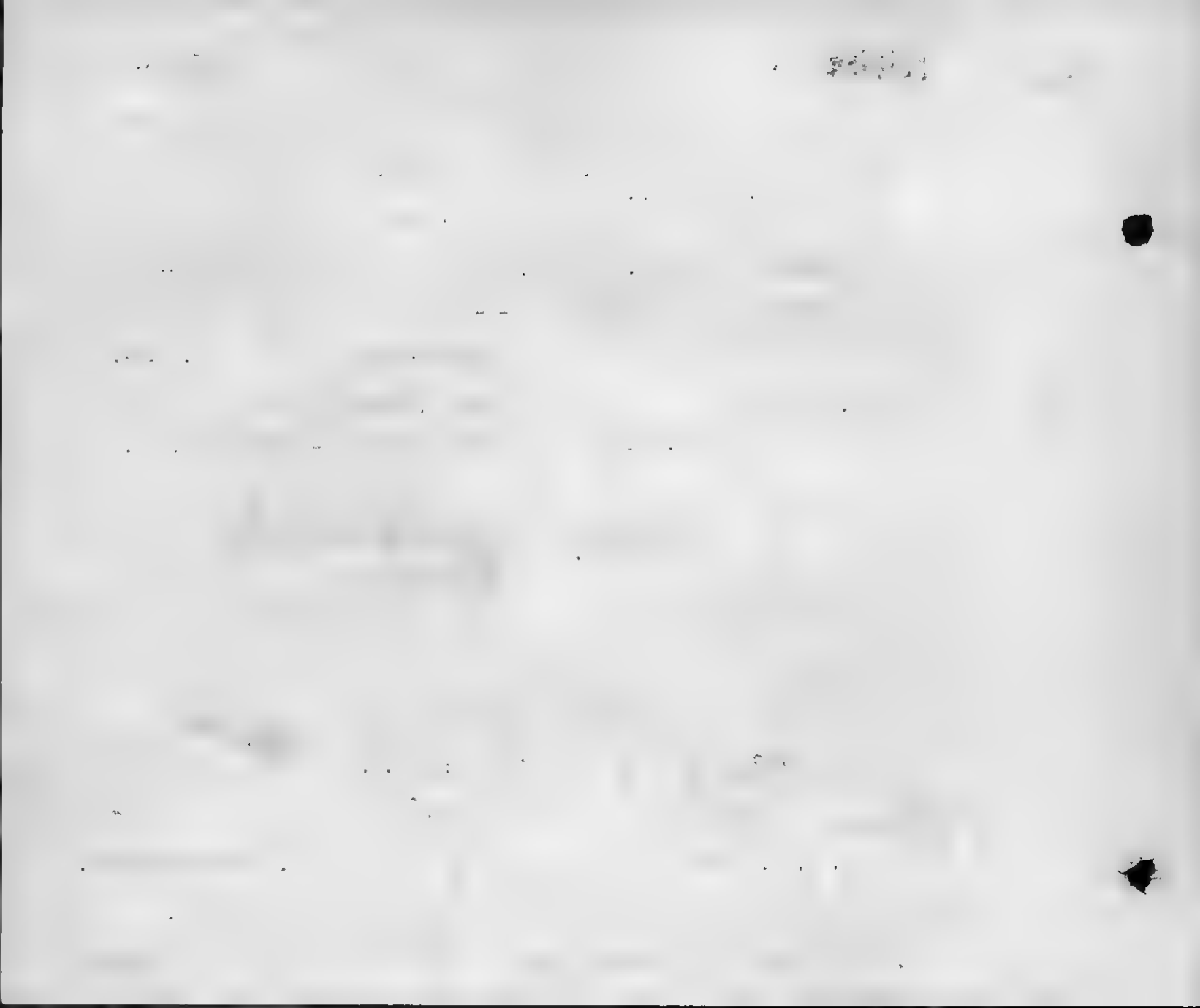
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Item 18 Filed 301 11-11-61 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12103 CERTIFICATE OF DEATH 13090

1. PLACE OF DEATH
a. COUNTY ALLEGANY MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
c. LENGTH OF STAY IN 1b 75 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If in hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE MARYLAND b. COUNTY ALLEGANY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND
d. STREET ADDRESS 138 WEST THIRD STREET
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) ZENA C. KESECKER
4. DATE OF DEATH NOVEMBER 15, 1961
5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED ☒ NEVER MARRIED ☐
8. DATE OF BIRTH 11-5-1911
9. AGE (In years) 50 yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Presser Undergarment Factory
11. BIRTHPLACE (County & State, or foreign country) NORTH CAROLINA U. S. A.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME AZORA L. BENNETT 14. MOTHER'S MAIDEN NAME MARY C. BONNER-BONNER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 215-20-6887 17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Retroperitoneal lymphosarcoma
DUE TO (b) Delayed Autopsy Report
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
Hour a.m. 19 p.m. While at work ☐ Not While at work ☐
21. I certify that (I) (this hospital) attended the deceased from 11:15 P.M. to 11:16 P.M., that (I) (we) last saw the deceased alive on NOV 15 1961, and that death occurred at 11:16 P.M. from the causes and on the date stated above.
22a. SIGNATURE OF PHYSICIAN DR. G. O. HIMMELWRIGHT 22b. DATE, SIGNED 11/16/61
22c. PHYSICIAN'S NAME (Type) DR. G. O. HIMMELWRIGHT 22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 11-18-1961 23c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park 23d. LOCATION (City, town or county) (State) Cumberland, Md.
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarjelli, Cumberland, Md. 25a. REC'D BY REGISTRAR NOV 17 '61 25b. REGISTRAR'S SIGNATURE Arthur L. House



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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

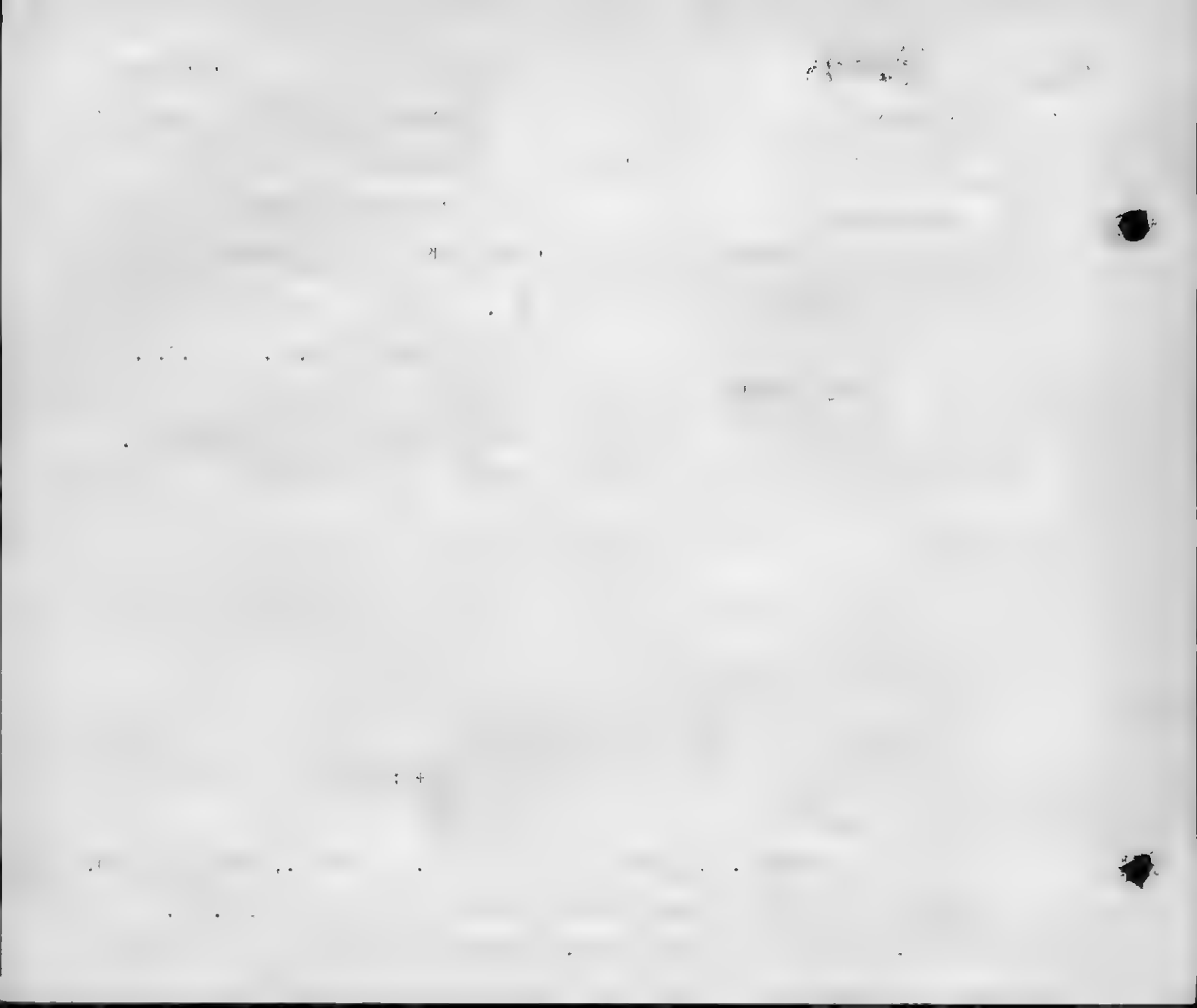
12104

CERTIFICATE OF DEATH

12091

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 301 BALTIMORE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ARVELLA		First		Middle		Last KILPATRICK		4. DATE OF DEATH NOVEMBER 8 1961		Month		Day		Year	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		B. DATE OF BIRTH DEC. 1, 1907		9. AGE 53/54 yrs.		10. USJAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) CACAPON BRIDGE, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ORVIS FLETCHER		14. MOTHER'S MAIDEN NAME MARGARET LARRICK		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-18-8280		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Carcinoma DUE TO (b) Annular Carcinoma Transverse Colon DUE TO (c) Transverse Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1531		INTERVAL BETWEEN ONSET AND DEATH 9 months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cumberland Alleg. Mpl.		20f. (City or town) Cumberland		20g. (County) Allegany		20h. (State) MD.	
21. I certify that (I) (this hospital) attended the deceased from 11/7/61 , 19 61 , to 11/8/61 , 19 61 , that (I) (we) last saw the deceased alive on 11/8/61 , 19 61 , and that death occurred 11/8/61 at 12:10 PM the causes and on the date stated above.		22a. SIGNATURE R. J. Williams		22b. DATE SIGNED 11/8/61		22c. PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS		22d. ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE 11/8/61		22g. SIGNATURE Arthur S. Hines	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/8/61		23c. NAME OF CEMETERY OR CREMATORY Fairview Lutheran Cemetery		23d. LOCATION (City, town or county) near Gore, W. Va.		23e. (State) MD.		25a. REC'D BY REGISTRAR NOV 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines		25c. DATE NOV 13 '61	
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		24a. ADDRESS Cumberland, Maryland		24b. DATE NOV 13 '61		24c. SIGNATURE Arthur S. Hines		24d. ADDRESS Cumberland, Maryland		24e. DATE NOV 13 '61		24f. SIGNATURE Arthur S. Hines		24g. ADDRESS Cumberland, Maryland	

VR A15 (4)
15M 9/60

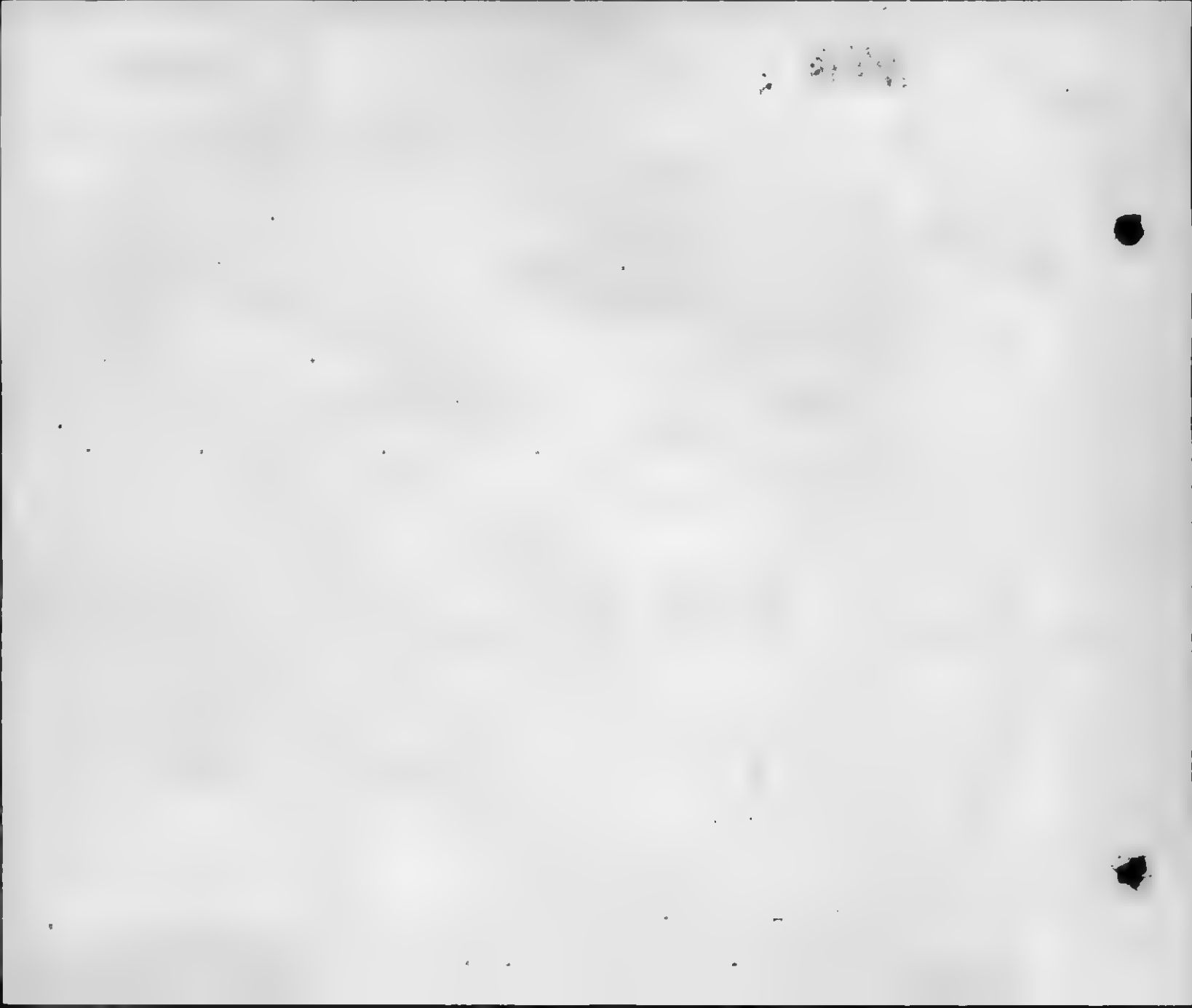


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

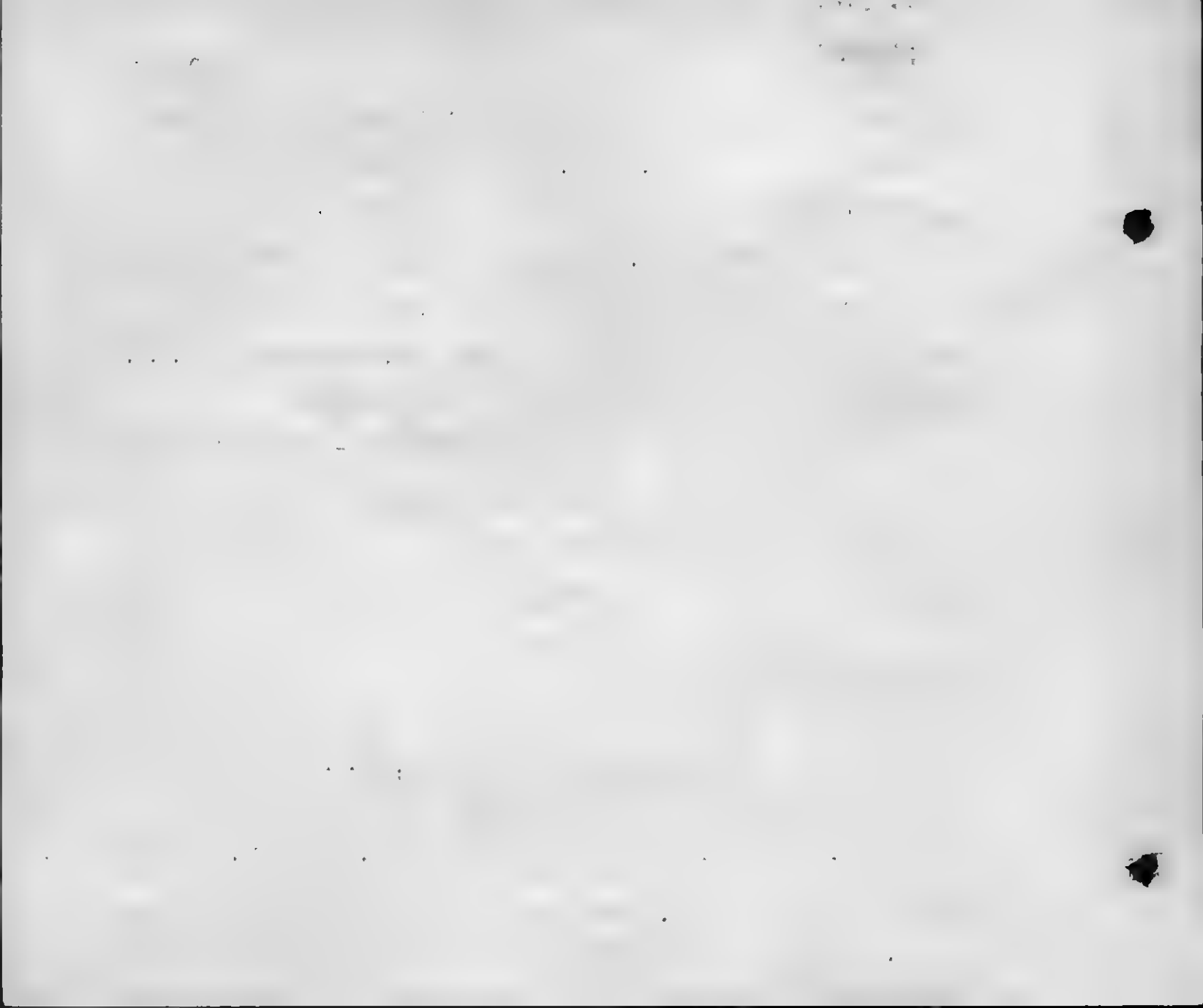
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12105 CERTIFICATE OF DEATH 12092											
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg c. LENGTH OF STAY IN 1b Lifetime d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Miners Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frostburg d. STREET ADDRESS 39 W. First St., F e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELLEN C. KOMATZ						4. DATE OF DEATH 11-27-61 Month 11 Day 27 Year 1961					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH 10-5-03		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR Months 11 Days 27 Hours 19		IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Frostburg, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Rafferty				14. MOTHER'S MAIDEN NAME Anastasia Scally				Address Frostburg, Md.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No				16. SOCIAL SECURITY NO None				17. INFORMANT Mr. Francis J. Komatz			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 570.1 DUE TO Cardiac dilatation, acute Conditions, if any, which gave rise to immediate cause (b) 9 lens, massive (c) 2 hrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 2) Dehydration (b) (1) Diabetes mellitus (c) (3) Hypertension (d) (4) Coronary insufficiency											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Frostburg		20f. City or town (County) Allegany (State) Md.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 3/29 to 11/27 , 19 61 , that (I) also last saw the deceased alive on 11/27 , 19 61 , and that death occurred at 11:35 M, from the causes and on the date stated above.											
22a. SIGNATURE Frank T. Harrat M.D.						22b. ADDRESS 26 W. Mechanic St. Frostburg, Md.		22c. DATE SIGNED 11/28/61		22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11-29-61		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cemetery		23d. LOCATION (City, town or county) Frostburg (State) Md.		23e. REC'D BY REGISTRAR Arthur E. Hines	
24. FUNERAL DIRECTOR'S SIGNATURE Bulah H. Hontela				24b. ADDRESS 23 E. MAIN, FROSTBURG, MD.		24c. DATE DEC 4 '61		24d. REGISTRAR'S SIGNATURE Arthur E. Hines		24e. DATE DEC 4 '61	



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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
12106											
12093											
1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 1 HR. 15 MIN.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				d. STREET ADDRESS 113 LENNOX PLACE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GERTINAE A. LAMBERT				4. DATE OF DEATH NOVEMBER 5 19 61				5. SEX FEMALE 6. COLOR OR RACE WHITE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH AUGUST 12, 1905				9. AGE (In years last birthday) 56 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MARYLAND			
13. FATHER'S NAME HARRY STEEPE				14. MOTHER'S MAIDEN NAME KATHERINE HIMMLER				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.				17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Artery Disease DUE TO (c) Generalized arteriosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus, Hypertension, Obesity 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from June 1948 to June 1961, that (I) (we) last saw the deceased alive on 11-3-1961, and that death occurred at 4:45 A.M. from the causes and on the date stated above.											
22a. SIGNATURE William P. James											
22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) DR. WILLIAM P. JAMES											
22d. ADDRESS 441 N. CENTRE ST., CUMBERLAND, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 11/8/61											
23c. NAME OF CEMETERY OR CREMATORY St. Lukes Cemetery											
23d. LOCATION (City, town or county) (State) Cumberland Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer											
25a. REC'D BY REGISTRAR NOV 9 61											
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas											



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12094

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN MD <u>60 years</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Md.</u> d. STREET ADDRESS <u>227 Offutt St.</u>	
3. NAME OF DECEASED (Type or print) <u>Addie Madore Lewis</u>		4. DATE OF DEATH <u>Nov. 1 1961</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 11, 1880</u> 9. AGE (In years last birthday) <u>81</u> yrs IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Sandy Hook, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Bissett</u> 14. MOTHER'S MAIDEN NAME <u>Ellen Holt</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr. Oscar J. Lewis, Cumberland, Md.</u> Address _____	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis CVD</u> (b) <u>Fracture of age</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) _____ 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Cumberland, Md.</u> 20f. City or town (County) (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>1/5/60</u> 19 <u>to</u> <u>11/1/61</u> 19 <u>that (I) (we) last saw the deceased alive on</u> <u>10/28/61</u> 19 <u>and that death occurred at</u> <u>5:15M</u> from the causes and on the date stated above. 22a. SIGNATURE <u>[Signature]</u> 22b. DATE SIGNED <u>Nov. 2, 1961</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Richard J. Williams</u> 22d. ADDRESS <u>122 S. Centre St., Cumberland, Md.</u> 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Nov. 4, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Harper Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Harpers Ferry, W. Va.</u> 24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u> 25a. REC'D BY REGISTRAR <u>NOV 6 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Finner</u>			

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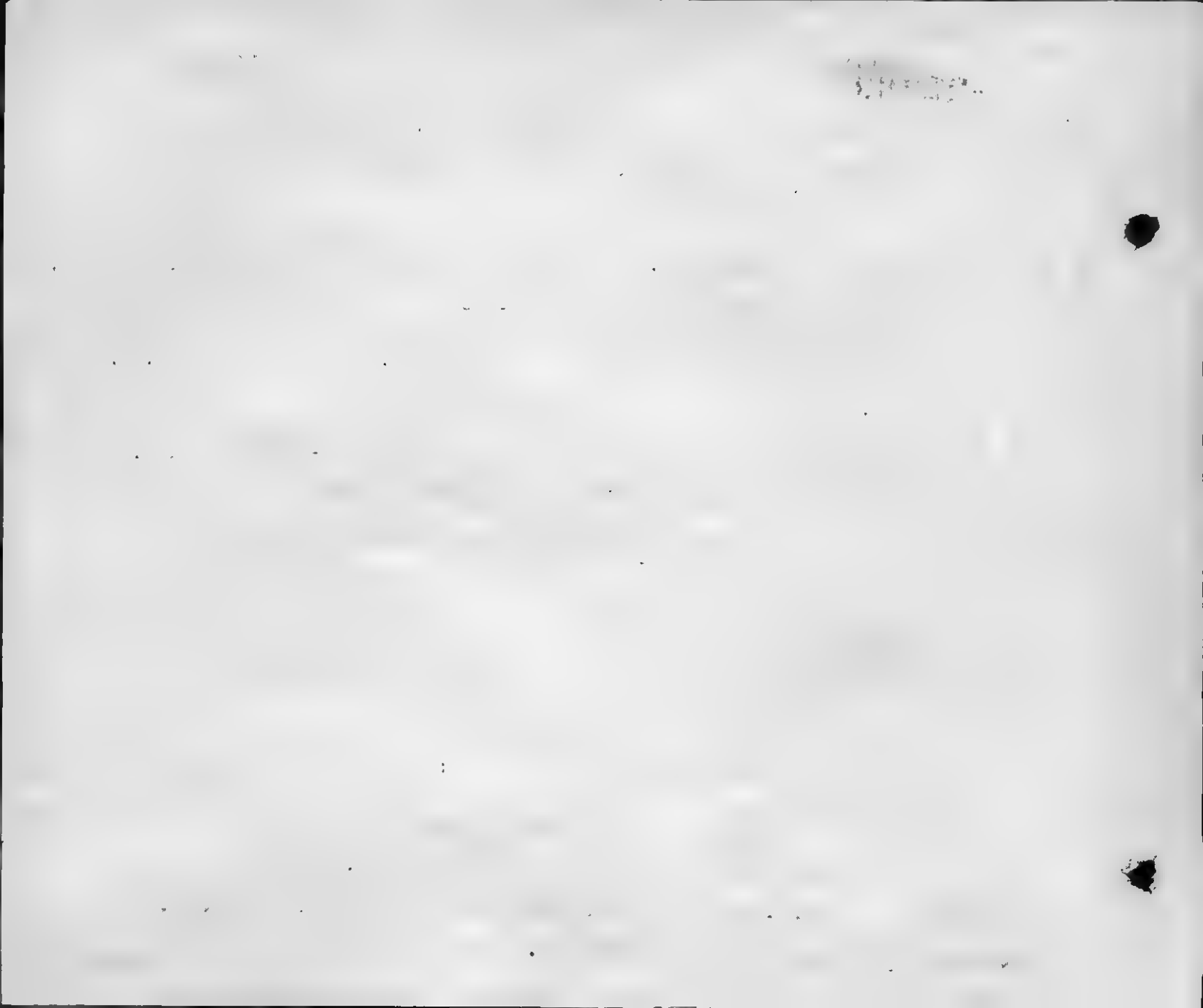
1941



VR A15 (4)
15M 9/60

12095

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if situation: Residence before admission) a. STATE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
c. LENGTH OF STAY IN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last		Month Day Year	
5. SEX		6. COLOR OR RACE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRAINDIC <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1961, to Nov. 29, 1961, that (I) (we) last saw the deceased alive on Nov. 28, 1961, and that death occurred at 3:40 P.M. from the causes and on the date stated above		22a. SIGNATURE Dr. John Topper	
22b. DATE SIGNED 11/30		22c. PHYSICIAN'S NAME (Type) DR. JOHN TOPPER	
22d. ADDRESS HYNDMAN, PA.		22e. REC'D BY REGISTRAR DATE DEC 4 '61	
22f. REGISTRAR'S SIGNATURE J. H. H. H.		23a. NAME OF CEMETERY OR CREMATORY Lybarger Cemetery	
23b. LOCATION (City, town or county) (State) Buffalo Mills, Pa. RD#1		23c. DATE THEREOF Dec. 2, 1961	
23d. BURIAL, CREMATION, REMOVAL (Specify)		23e. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Heigler	



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15M 9/60

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MARYLAND STATE DEPARTMENT OF HEALTH

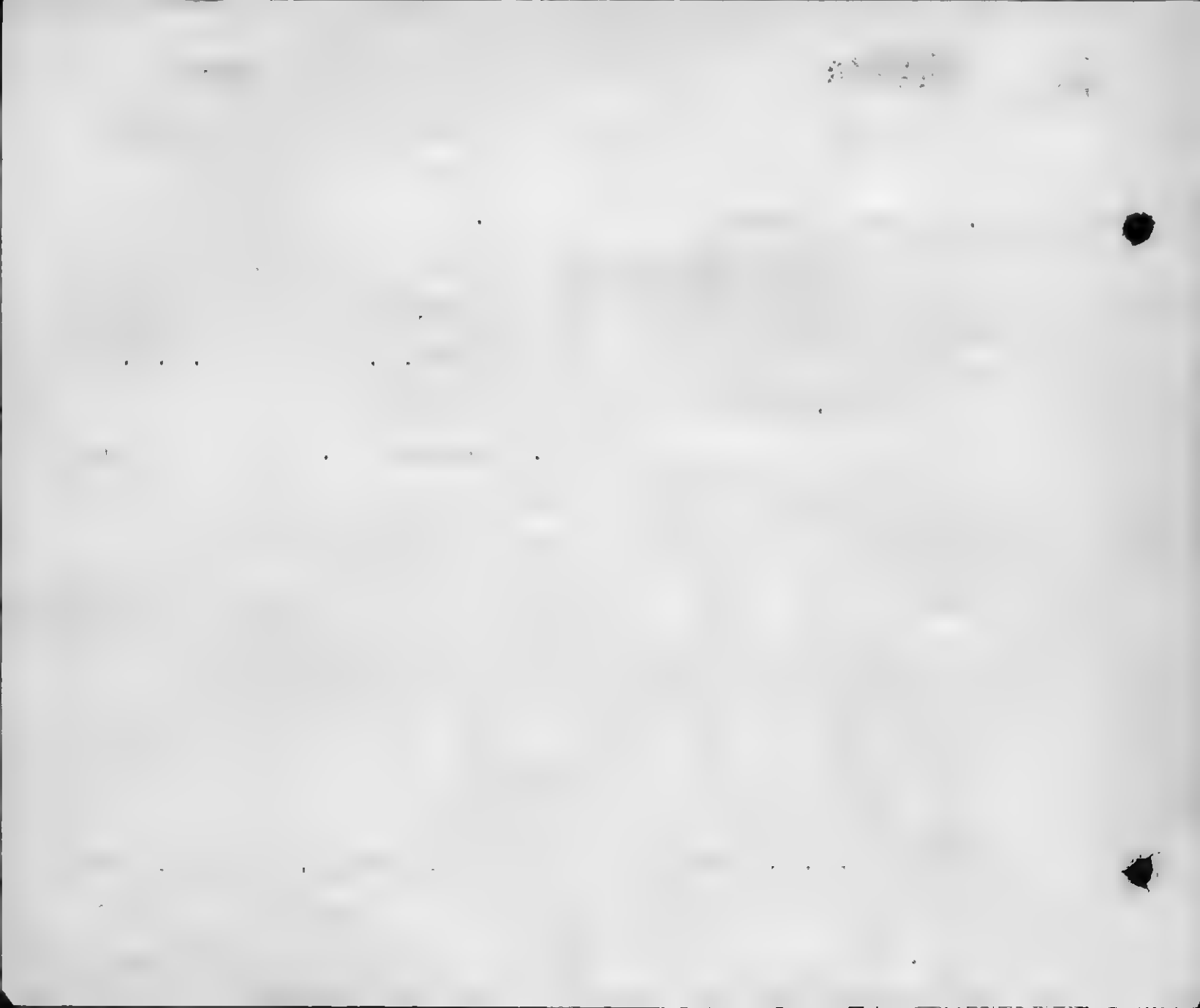
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12109

CERTIFICATE OF DEATH

1209C

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland (Rural)</u>	
c. LENGTH OF STAY IN <u>50 yrs</u>		d. STREET ADDRESS <u>Rt. # 2 Naves Crossroads</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. # 2 Naves Crossroads</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EMMA</u> Middle <u>EFFIE</u> Last <u>MARTIN</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>18</u> Year <u>19 61</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October <u>21</u> , 189 <u>6</u> <u>65</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Terra Alta, W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Oscar F. Forguer</u>		14. MOTHER'S MAIDEN NAME <u>Rhoda Jackson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. Carl Martin</u> 17. INFORMANT <u>Rt. 2 Naves Crossroads</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>260X</u> DUE TO (b) <u>arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Diabetes mellitus</u> PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gen. Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>2 years</u> <u>5 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>any</u> 19 <u>61</u> to <u>18 Nov.</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>16 Nov.</u> 19 <u>61</u> , and that death occurred at <u>4 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>W. Alfred Van Ormer</u>		22b. DATE SIGNED <u>18 Nov 61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. W. A. Van Ormer</u>		22d. ADDRESS <u>122 S. Centre St. Cumberland, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/20/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		23d. LOCATION (City, town or county) (State) <u>Cumberland Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		25a. REC'D BY REGISTRAR <u>NOV 21 '61</u>	
ADDRESS <u>Cumberland, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	



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VR A15 (4)
ISM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

121110

12097

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>223 Carroll St.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>223 Carroll St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Helen Mary McKenzie</u> First Middle Last 4. DATE OF DEATH <u>November 12, 1961</u> Month Day Year 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>August 7, 1885</u> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/> 9. AGE (In years last birthday) <u>76</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10a. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Cumberland, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Enoch A. McKenzie</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>17. INFORMANT</u> <u>Mrs. Lawrence Manthey, Cumberland, Maryland</u> Address <u>4 days ago</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Roman</u> 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cornary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> (c) <u>Myocardial infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4 days ago</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>June 3, 1961</u> to <u>11/12</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>11/12</u> , 19 <u>61</u> , and the death occurred at <u>11/13</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>George M. Brown</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>George M. Brown</u> 22d. ADDRESS <u>11/13/61</u>		22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Nov. 15, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cemetery Cumberland, Maryland</u> 23d. LOCATION (City, town or county) (State)		25a. REC'D BY REGISTRAR <u>NOV 16 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc</u> 24a. ADDRESS <u>17 Frederick St. Cumb., Md.</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

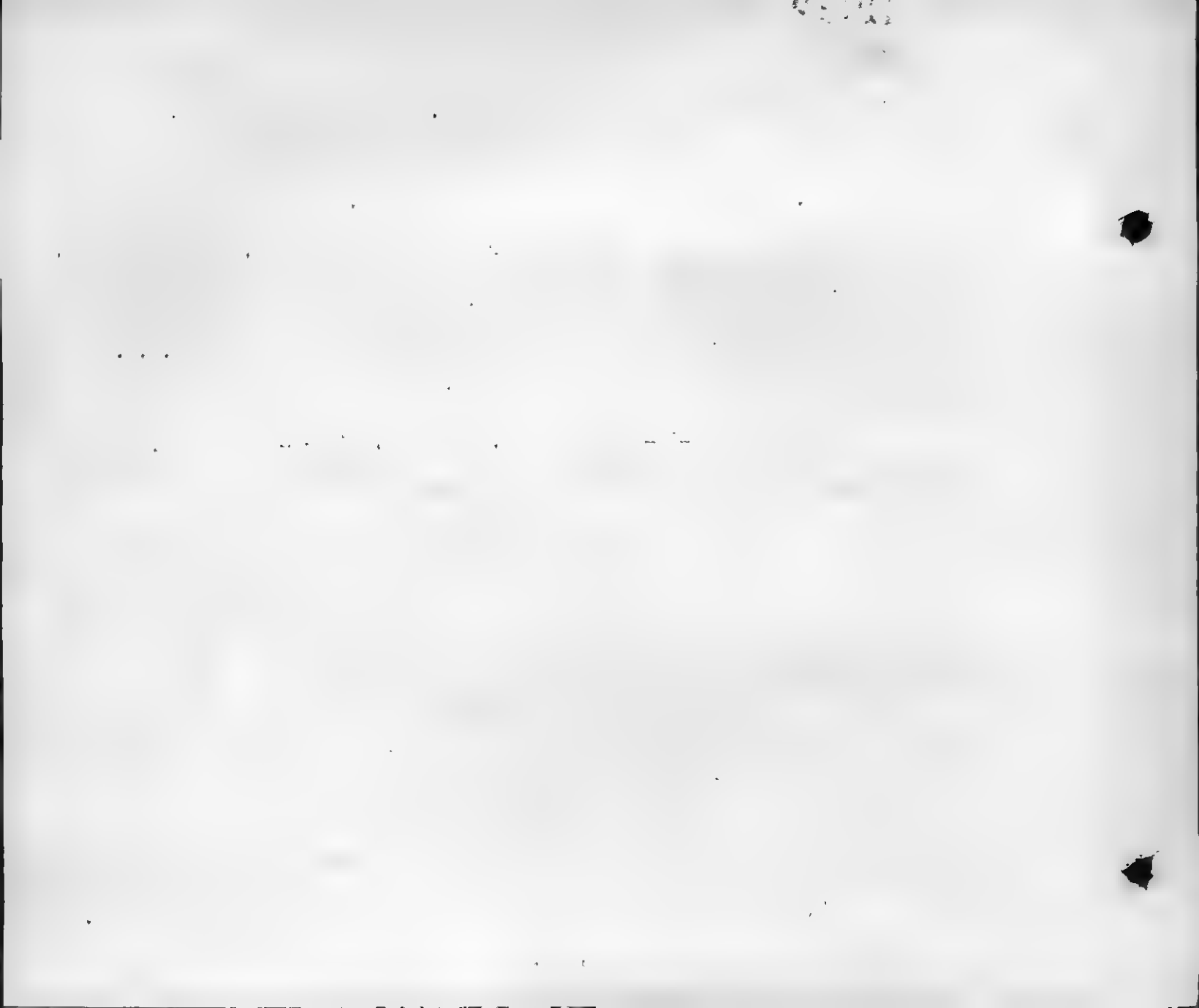
VR A15 (4)
ISM 9/59

12111

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12098

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		c. LENGTH OF STAY IN 1b 35 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Star Rt..		d. STREET ADDRESS Star Rt.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edward First Stanley Middle Miller Last		4. DATE OF DEATH Month Nov. Day 21 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 5, 1900
9. AGE (In years lost birthday) 61 yrs.		IF UNDER 1 YEAR Months 61 Days 61 Hours 61 Min.	IF UNDER 24 HRS Months 61 Days 61 Hours 61 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Brewery	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Columbus Miller		14. MOTHER'S MAIDEN NAME Alice Clark	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-10-8084	17. INFORMANT Mrs. Edward S. Miller-Barton, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkins Disease 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 201X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Westernport		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec 12, 1960 to Nov 20, 1961 that (I) (we) last saw the deceased alive on Nov 20, 1961 and that death occurred at 6 P.M. from the causes and on the date stated above.			
22a. SIGNATURE William W. Lesh		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) WILLIAM W. LESH, M.D.		22d. ADDRESS 90 Main St. 2nd International, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/24/61	23c. NAME OF CEMETERY OR CREMATORY Philos
23d. LOCATION (City, town, or county) Westernport		(State) Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. J. Boal		ADDRESS Westernport, Md.	
25a. REC'D BY REGISTRAR NOV 27 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kline	

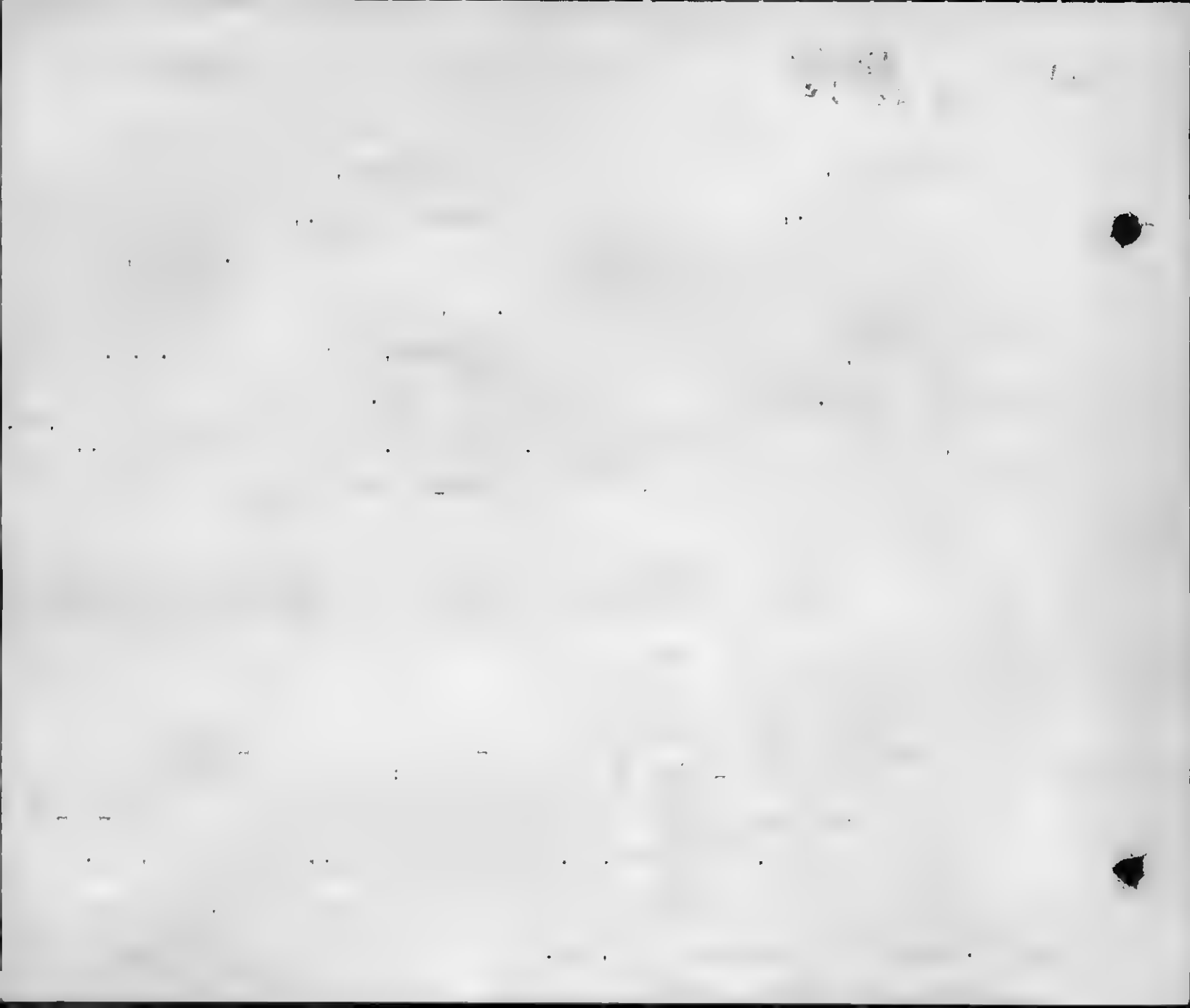


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12112					12099				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)				
a. COUNTY Allegany					a. STATE Maryland b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,				
c. LENGTH OF STAY IN 1b					d. STREET ADDRESS 58 Greene St.,				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 58 Greene St.,					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First FLORA Middle WOLFE Last MILLER					Month Nov. Day 14, Year 1961				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH Oct. 20, 1867 94 yrs.				
9. AGE (In years last birthday)					10. IF UNDER 1 YEAR: Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife,					10b. KIND OF BUSINESS OR INDUSTRY Own home				
11. BIRTHPLACE (County & State, or foreign country) Frederick, Maryland					12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Cornelius A. Wolfe					14. MOTHER'S MAIDEN NAME Elmira E. Jacobs				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,					16. SOCIAL SECURITY NO. None				
17. INFORMANT Mr. Walter L. Miller					Address Cumberland, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					INTERVAL BETWEEN ONSET AND DEATH 10 years				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio-vascular disease									
422.1 DUE TO									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					(b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (th) hospital attended the deceased from 2 - 26 19 56 to 11 - 14 19 61 that (I) (we) last saw the deceased alive on 11 - 14 19 61 and that death occurred at 7:00 PM from the causes and on the date stated above.									
22a. SIGNATURE Ralph W. Ballin M.D.									
22b. DATE SIGNED 11-15-61									
22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin M. D.									
22d. ADDRESS 62 Greene St., Cumberland, Md.									
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) Burial 11/17/61									
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Mausoleum									
23d. LOCATION (City, town or county) (State) Cumberland, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.									
25a. REC'D BY REGISTRAR NOV 17 '61									
25b. REGISTRAR'S SIGNATURE Arthur S. House									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12113

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 2, MARYLAND CERTIFICATE OF DEATH

12100

1. PLACE OF DEATH e. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN b 2 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) FROSTBURG d. STREET ADDRESS 184 ORMOND STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STELLA 5. SEX FEMALE 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH FEBRUARY 1, 1892 9. AGE (In years last birthday) 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. NOVEMBER 22, 1961		4. DATE OF DEATH NOVEMBER 22, 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Housework 11. BIRTHPLACE (County & State or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ELMER MILLER 14. MOTHER'S MAIDEN NAME SARAH LEWIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 213-09-6398 16. SOCIAL SECURITY NO. 213-09-6398 17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 422.1 DUE TO Chronic Hepatitis & Membrane (b) Arteriosclerosis Myocardial Degeneration (c) INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office, b.d.g., etc.) Cumberland Allegany Md	
21. I certify that (I) (this hospital) attended the deceased from 7/6/60 19... to 11/22/61 19... that (I) (we) last saw the deceased alive on 11/21/61 19... and that death occurred at 2:05 PM on the causes and on the date stated above. 22a. SIGNATURE DR. R. J. WILLIAMS 22b. PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS 22c. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 122 SO. CENTRE STREET, CUMBERLAND, MD.		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 11-24-1961 23c. NAME OF CEMETERY OR CREMATORY FROSTBURG-MEMORIAL PARK FROSTBURG-ALLEG. MD. 23d. LOCATION (City, town or county) (State) FROSTBURG-ALLEG. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Burt, Frostburg, Md 25a. REC'D BY REGISTRAR NOV 27 '61 25b. REGISTRAR'S SIGNATURE Charles S. Kinn			

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12114

12101

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> c. LENGTH OF STAY IN <u>8 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> d. STREET ADDRESS <u>118 WINTON PLACE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARGARET R. MITCHELL</u> First Middle Last 4. DATE OF DEATH <u>11 24 19 61</u> Month Day Year		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady Retired Shoe Store</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>WEST VIRGINIA</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. DATE OF BIRTH <u>7/10/86</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <u>WILLIAM MITCHELL</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>214-05-5424</u> 17. INFORMANT <u>MARY JOYCE</u> Address <u>120 Winton Place, Cumb. Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> 260X DUE TO (b) <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>6 mos</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 14</u> 19 <u>61</u> to <u>Nov. 24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov. 24</u> 19 <u>61</u> , and that death occurred at <u>8:45 P.</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Clay R. Durrett</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>CLAY DURRETT</u> 22d. ADDRESS <u>236 VIRGINIA AVE. CUMB. MD.</u> 22e. DATE SIGNED <u>11/25/61</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Nov. 27, 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cem. Cumberland, Md.</u> 23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Md.</u> ADDRESS 25a. REC'D BY REGISTRAR <u>NOV 27 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Clayton S. Harris</u>	

1934

TO DISTRICT CLERK: This certificate should be submitted with in 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

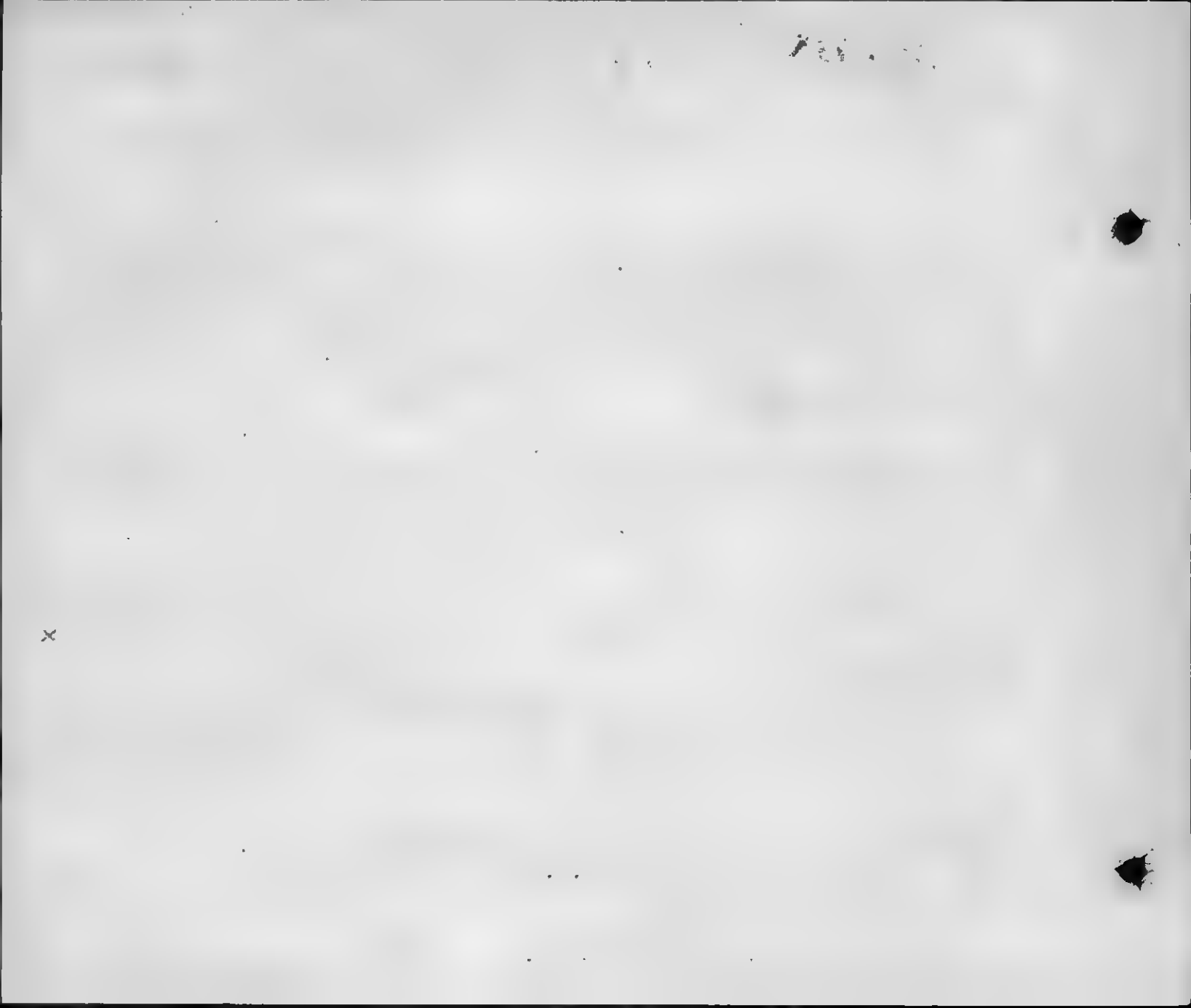
FOR STATE
HEALTH DEPT.

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH														
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
12115 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12102														
1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>					c. LENGTH OF STAY IN 1b <u>60 years</u>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1027 Penhurst St.</u>					d. STREET ADDRESS <u>1027 Penhurst St.</u>									
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>L.</u> Last <u>Morris</u>					4. DATE OF DEATH Month <u>Nov.</u> Day <u>9</u> Year <u>19 61</u>									
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 28, 1901</u>		9. AGE (In years last birthday) <u>60</u> yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
13. FATHER'S NAME <u>John H. Morris</u>					14. MOTHER'S MAIDEN NAME <u>Beulah Norris</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>					16. SOCIAL SECURITY NO. <u>Mr. George W. Morris, Cumberland, Md</u>					17. INFORMANT <u>Mr. George W. Morris, Cumberland, Md</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>7:00</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CORONARY SCLEROSIS</u> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 9, 1961 Address (Street, city, town, or county) ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D. DATE SIGNED EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u> 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> 22b. DATE THEREOF <u>11-11-61</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u> 22d. LOCATION (City, town, or country) (State) <u>Cumberland, Md.</u> 23. FUNERAL DIRECTOR ADDRESS <u>James F. Scarpelli, Cumberland, Md.</u> 24a. REC'D BY REGISTRAR <u>NOV 14 '61</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>														

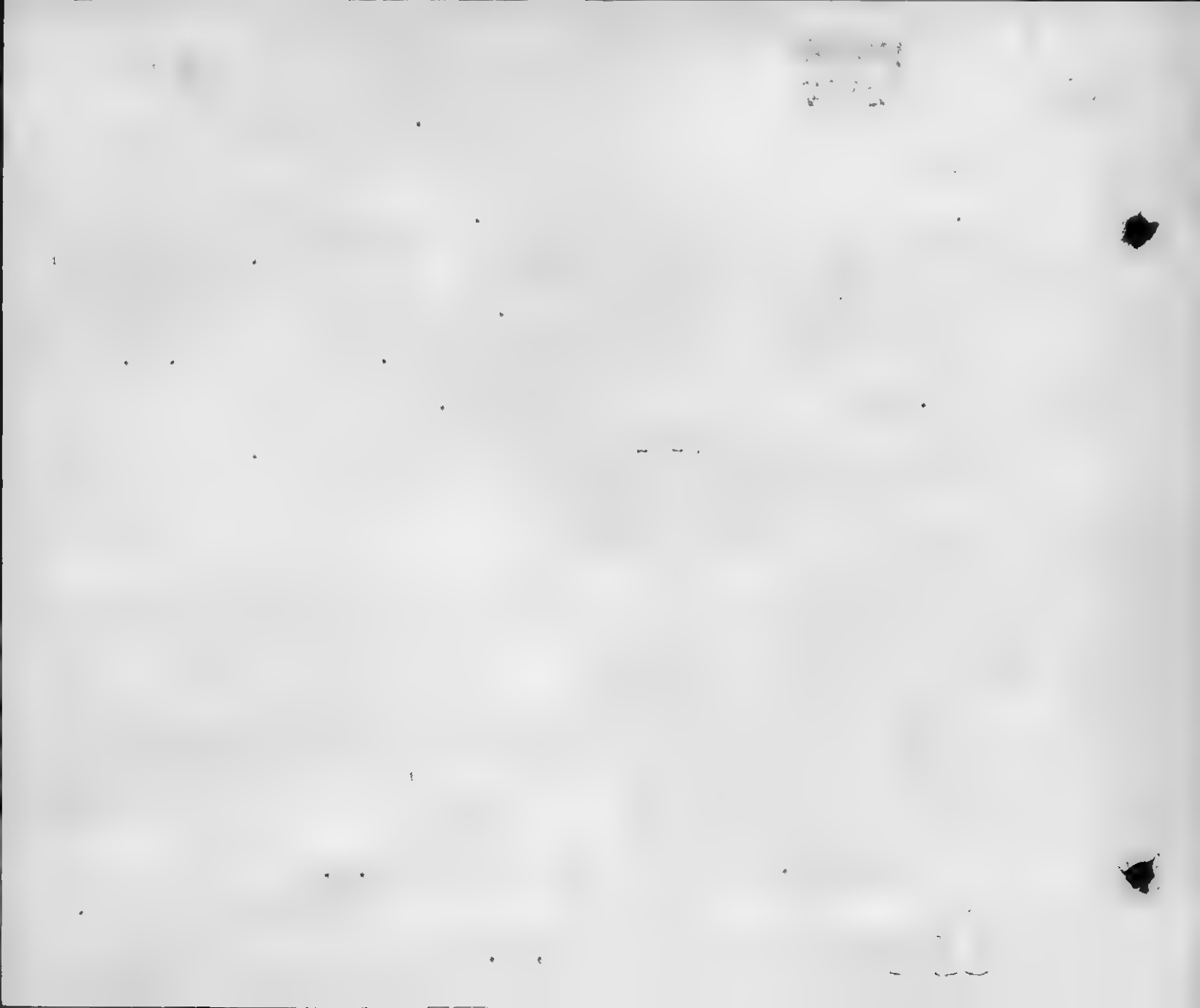


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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed and signed by the funeral director. After this certificate has been signed by the attending physician and completed and signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
12118													
12103													
1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton c. LENGTH OF STAY IN 1b 68 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) S. Utah						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton d. STREET ADDRESS S. Utah e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) John Mowbray						4. DATE OF DEATH Nov. 14 1961							
5. SEX Male COLOR OR RACE White						6. DATE OF BIRTH Dec. 12, 1892							
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. AGE (In years last birthday) 68 yrs.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner						10b. KIND OF BUSINESS OR INDUSTRY Coal Mine							
11. BIRTHPLACE (County & State, or foreign country) Barton, Md.						12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John M. Mowbray						14. MOTHER'S MAIDEN NAME Mary L. Darnley							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no						16. SOCIAL SECURITY NO. 213-10-5931							
17. INFORMANT Maude Mowbray-Barton, Md.						Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Artery Disease 420.1 DUE TO (b) Embolus Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH 30 Minutes 30 Minutes	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Nov. 14, 1961 , to Nov. 14, 1961 , that (I) (we) last saw the deceased alive on Nov. 14, 1961 , and that death occurred at 1:30 M, from the causes and on the date stated above.													
22a. SIGNATURE Paul R. Wilson						22b. DATE SIGNED Nov. 15, 1961							
22c. PHYSICIAN'S NAME (Type) Paul R. Wilson						22d. ADDRESS Piedmont, W. Va.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/16/61		23c. NAME OF CEMETERY OR CREMATORY Laurel Hill		23d. LOCATION (City, town or county) (State) Moscow Mills Md.					
24. FUNERAL DIRECTOR'S SIGNATURE E.S. Boal						ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR NOV 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

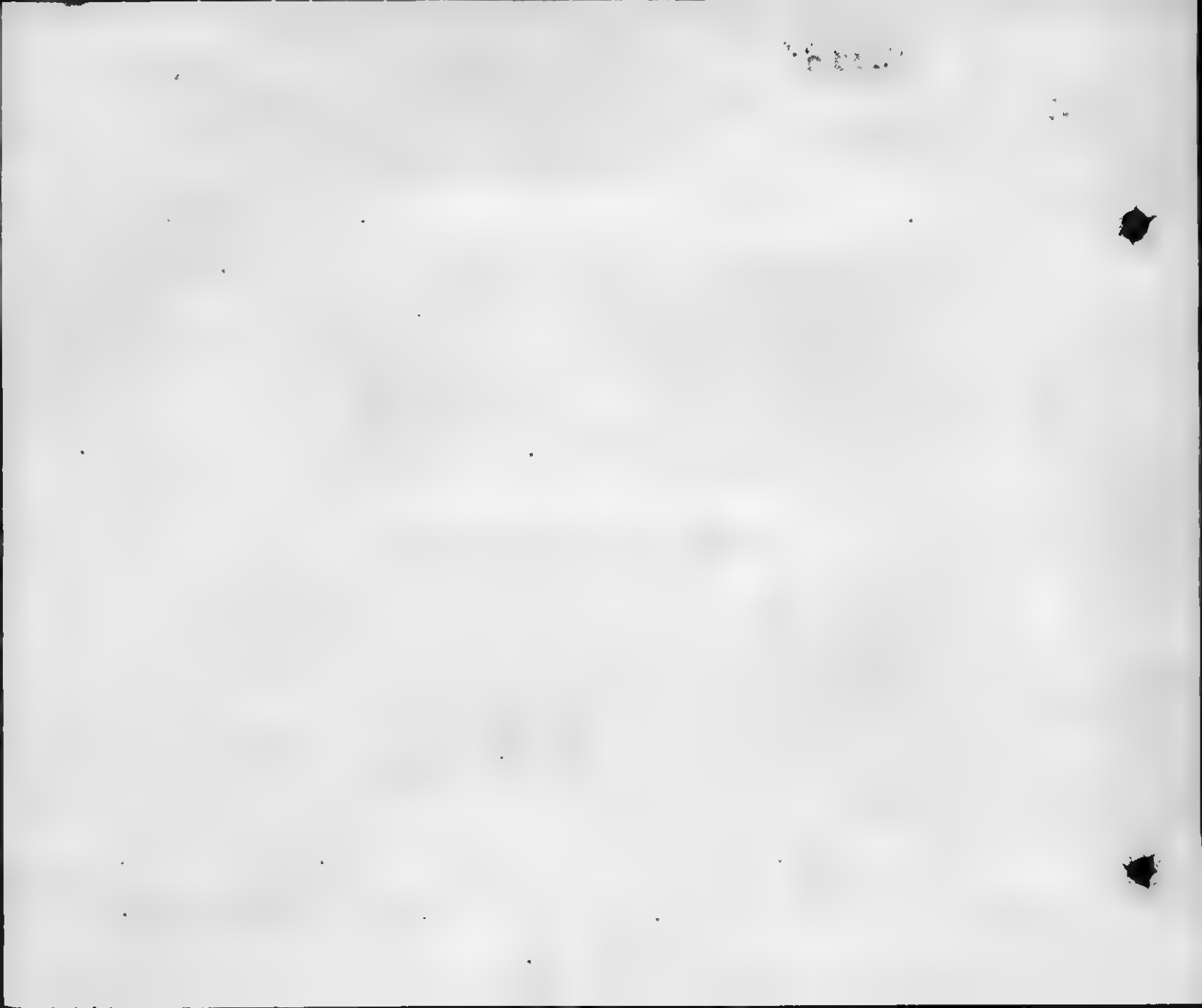
12117

12104

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN It <u>65 years</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>112 N. Smallwood Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> d. STREET ADDRESS <u>112 N. Smallwood St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>E.</u> Last <u>Naughton</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>2</u> Year <u>19 61</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 22, 1877</u>		9. AGE (In years) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>19</u> Min. <u>61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Train Master Railroad</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Barton, Maryland</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Michael Patrick Naughton</u> 14. MOTHER'S MAIDEN NAME <u>Ann Dailey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr. Harold Naughton, Cumberland, Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Brain Cerebro-vascular accident embolus</u> (c) <u>10 days</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial fibrosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. <u>19</u> p.m.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/27/61</u> to <u>11/2/61</u> , 19 , that (I) (we) last saw the deceased alive on <u>10/27/61</u> , 19 , and that death occurred at <u>11:15 P</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Samuel M. Jacobson</u>		22b. DATE SIGNED <u>11/6/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Samuel M. Jacobson, M. D.</u>		22d. ADDRESS <u>50 Pershing St. Cumberland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Nov. 6, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter & Paul Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Cumberland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 7 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

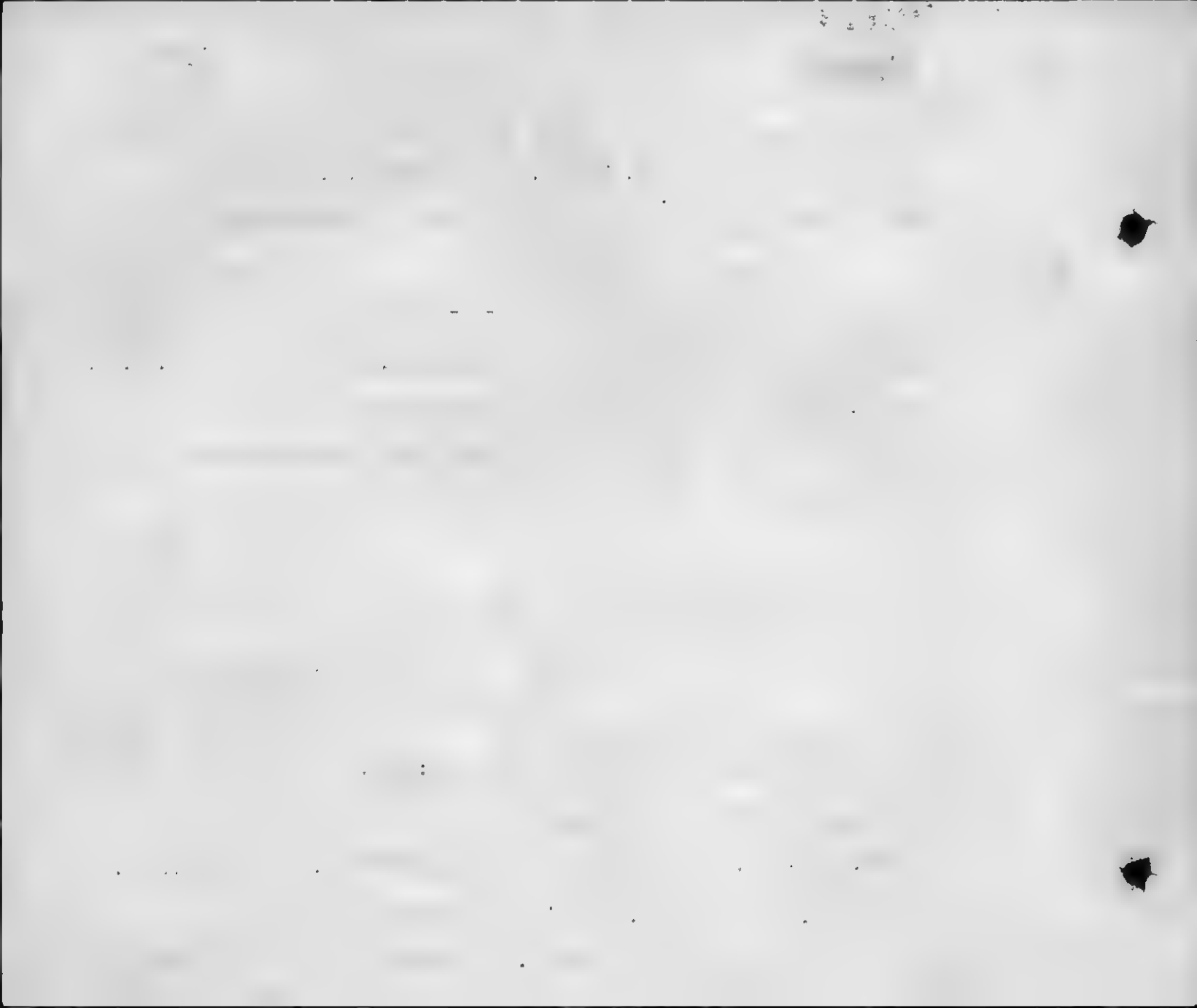
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15M 9/60

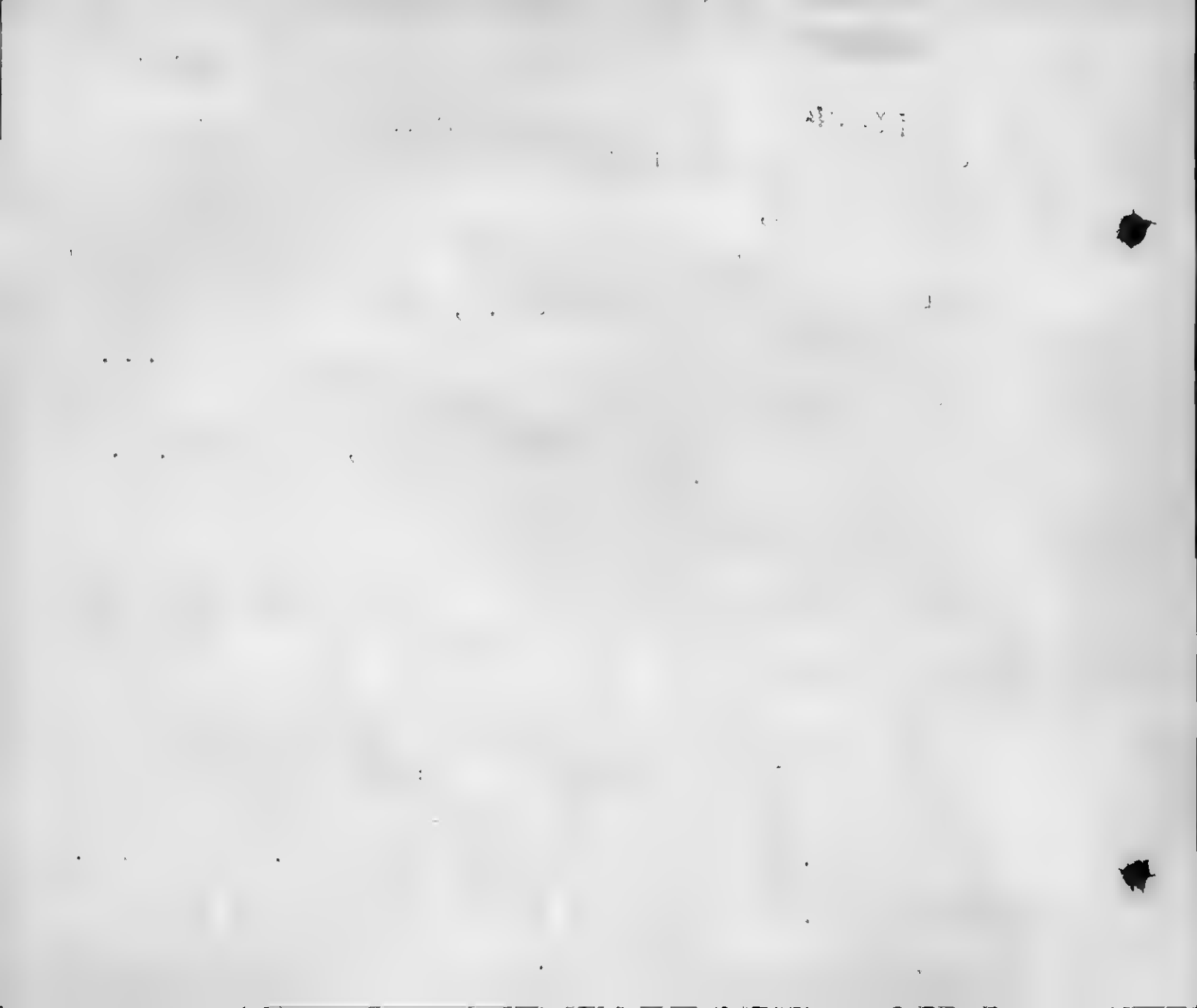
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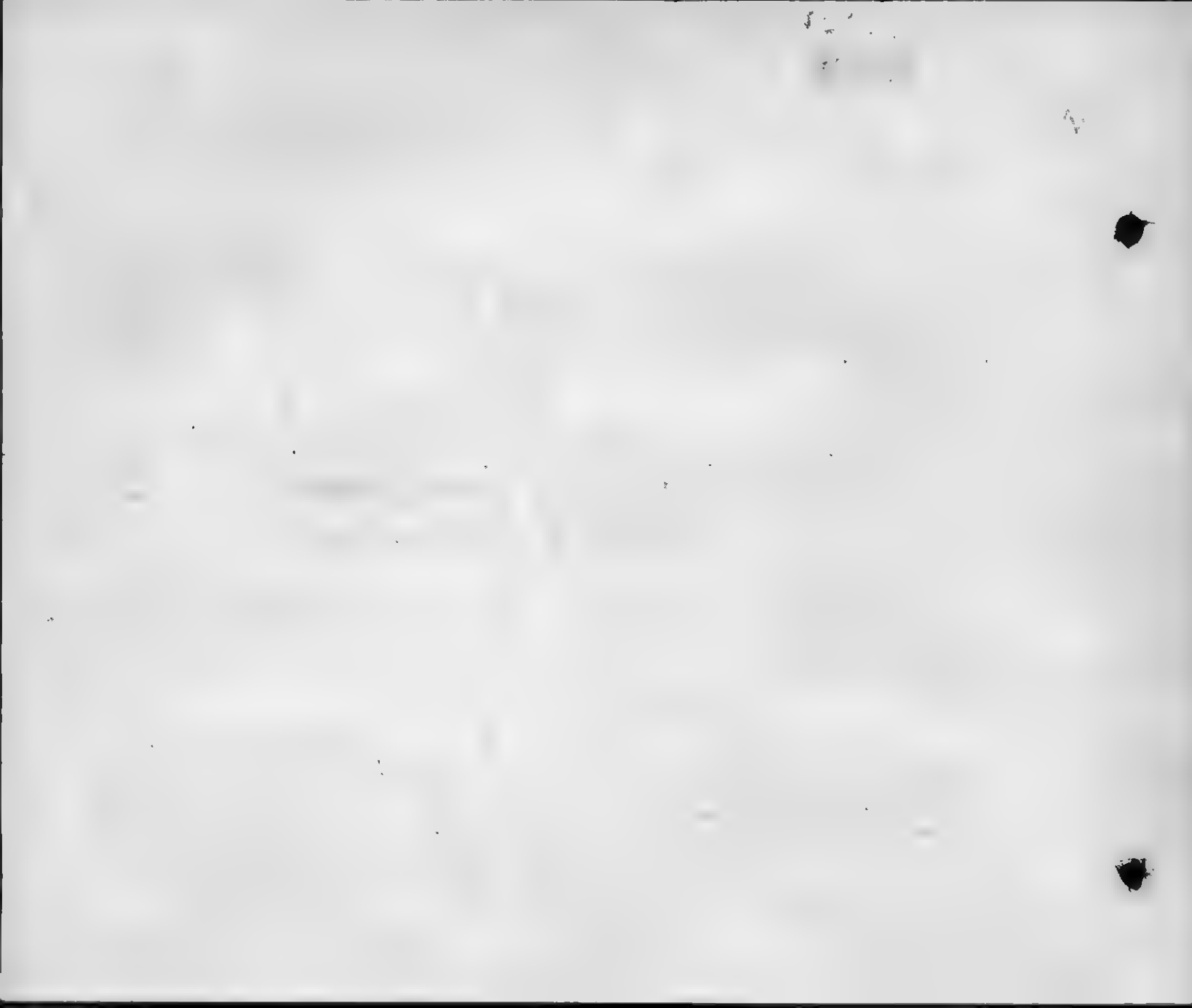
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12118
CERTIFICATE OF DEATH
12105

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 HRS. 51 MIN.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LAVALE, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) MEMORIAL & WARWICK AVES. MEMORIAL HOSPITAL		d. STREET ADDRESS 1107 NATIONAL HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BABY BOY NIES		4. DATE OF DEATH NOVEMBER 21, 1961		Month Day Year	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> W DOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		8. DATE OF BIRTH 11-21-1961	
11. BIRTHPLACE (County & State, or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U. S. A.		9. AGE (in years last birthday) Months Days Hours Min. 2 51	
13. FATHER'S NAME LOUIS L. NIES		14. MOTHER'S MAIDEN NAME SUE ANN WAGNER		Address	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause last. (c) Prematurity 26-27 weeks PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 19		20g. (County) 19		20h. (State) 19	
21. I certify that (I) (this hospital) attended the deceased from 2:40 P.M. to 19 , that (I) (we) last saw the deceased alive on 21 Nov 1961 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Fuller B. Whitworth M.D.		22b. ADDRESS 123 BEDFORD ST., CUMBERLAND, MD.		22c. PHYSICIAN'S NAME (Type) DR. FULLER B. WHITWORTH	
22d. ADDRESS 123 BEDFORD ST., CUMBERLAND, MD.		22e. REC'D BY REGISTRAR NOV 28 '61		22f. REGISTRAR'S SIGNATURE Charles P. F...	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 22, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION (City, town or county) Cumberland, Md.		23e. (State) Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarielli		24a. ADDRESS Cumberland, Md.		24b. DATE NOV 28 '61	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

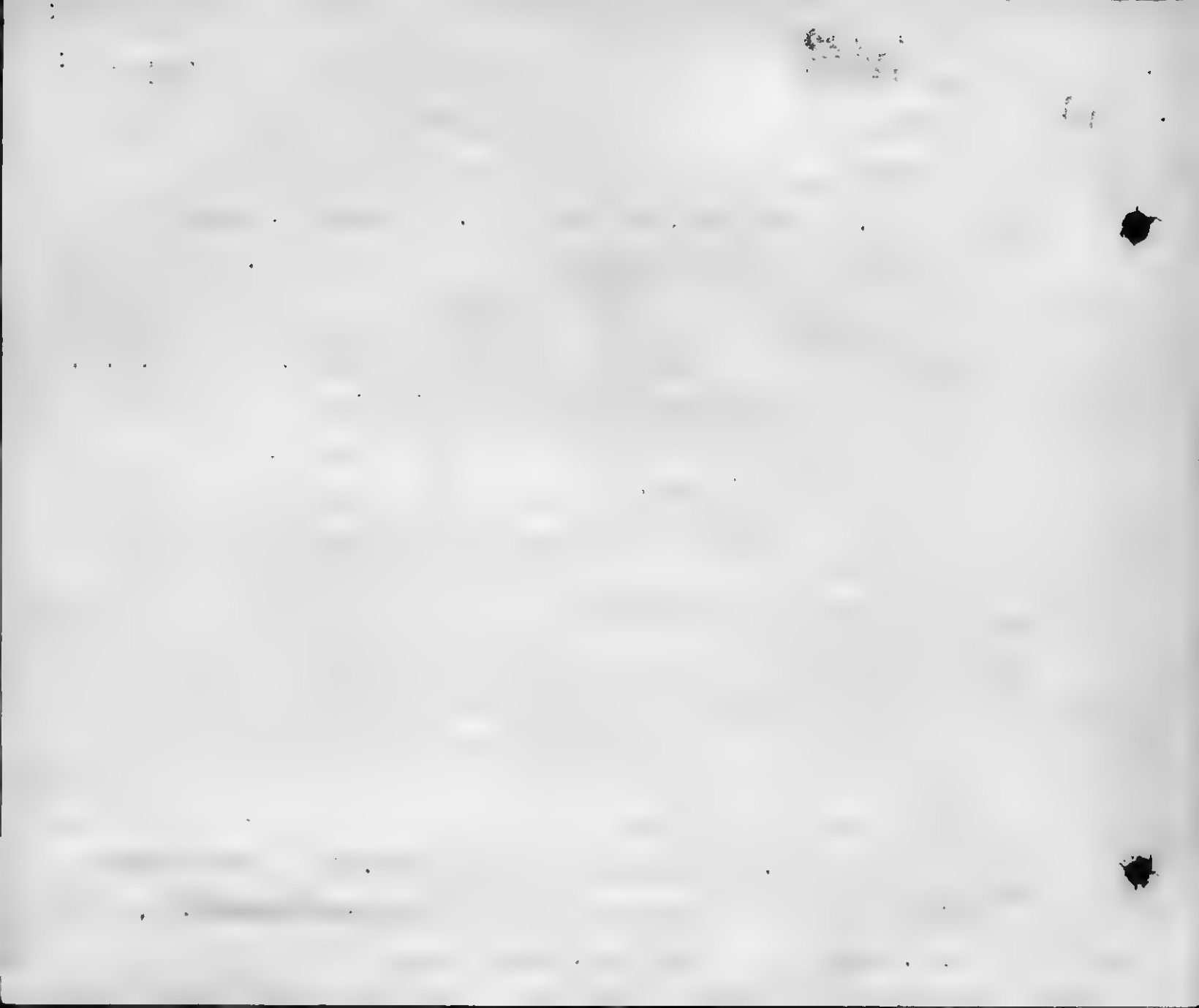
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12121

12108

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Rt. # 1 Cumberland, Maryland</u>				d. STREET ADDRESS <u>Rt. # 1 Cumberland, Maryland</u>			
3. NAME OF DECEASED (Type or print) <u>George Washington Andrews Nycum</u>				4. DATE OF DEATH <u>Nov. 9 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIAGE <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH <u>4/25/1881</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clearville, Pennsylvania</u>		9. AGE (In years last birthday) <u>80 yrs.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Wesley Nycum</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Miller</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>331X</u>				17. INFORMANT <u>Interval between onset and death</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>months</u> <u>year</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1957</u> to <u>11/9</u>, 19<u>61</u>; that (I) (we) last saw the deceased alive on <u>11/7</u>, 19<u>61</u>, and that death occurred at <u>11/9</u>, 19<u>61</u>, from the causes and on the date stated above.							
22a. SIGNATURE <u>George M. Simons</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11/10/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George M. Simons</u>				22d. ADDRESS <u>Baltimore St., Cumberland, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/11/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fairview Christian Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Inglesmith, Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>				25a. REC'D BY REGISTRAR <u>Cumberland, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Nov 16 '61</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

CERTIFICATE OF DEATH

12122

12109

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> <u>50 yrs</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> d. STREET ADDRESS <u>512 Eastern Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Dora Helene Perdew</u>		4. DATE OF DEATH <u>Nov. 5 19 61</u>		9. AGE (in years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>19</u> Hours <u>61</u> Min.	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Green Ridge, Maryland</u>	
13. FATHER'S NAME <u>Leonard S. Crabtree</u>		14. MOTHER'S MAIDEN NAME <u>Fannies Meyers</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>Charles H. Perdew</u>		17. INFORMANT <u>512 Eastern Ave.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>		5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2 - 11</u> , 19 <u>59</u> <u>11</u> - <u>5</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>11-2</u> , 19 <u>61</u> , and that death occurred at <u>11 a.m.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>Ralph W. Ballin</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-7-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin, M.D.</u>		22d. ADDRESS <u>62 Greene St. Cumberland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/8/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>	
23d. LOCATION (City, town or county) <u>Cumberland, Maryland</u>		23e. (State)		23f. (Country)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer</u>		ADDRESS <u>Cumberland</u>		25a. REC'D BY REGISTRAR <u>NOV 9 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Carleton S. Kraus</u>		25c. DATE			

1944

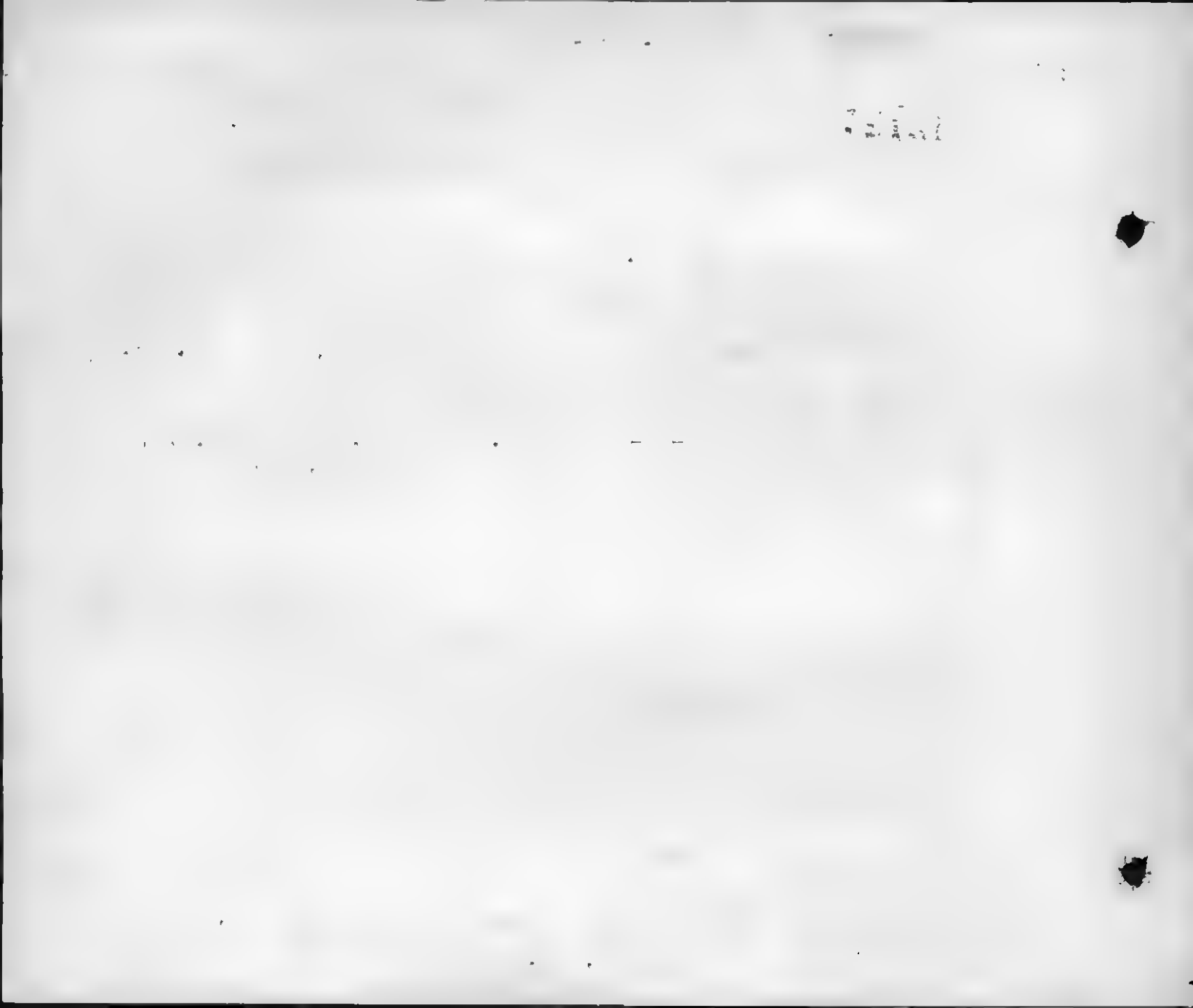


12123

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

12110

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural # 1 Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural # 1 Frostburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Thomas Middle L. Last Plummer				4. DATE OF DEATH 11/1/1961 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/26/1884	9. AGE (in years last birthday) 77 yrs	10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cola Miner				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Borden Shaft, MD.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Thomas Plummer			
14. MOTHER'S MAIDEN NAME Lavena Loar				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service			
16. SOCIAL SECURITY NO 213-09-6463				17. INFORMANT Address Mrs. Thomas L. Plummer R.F.D. #1 Frostburg, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of esophagus with Metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH about 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from 4/12 19 60 to 8/9 19 61 , that (I) (we) last saw the deceased alive on 8/9 19 61 , and that death occurred at 3:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Calvin Y. Hadidian				22b. DATE SIGNED 11/1/61		22c. PHYSICIAN'S NAME (Type) CALVIN Y. HADIDIAN	
22d. ADDRESS ALGONQUIN HOTEL				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/3/1961		23c. NAME OF CEMETERY OR CREMATORY Memorial Park	
23d. LOCATION (City, town, or county) (State) Frostburg, MD.				24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN ADDRESS LONA CONING, MD.			
25a. REC'D BY REGISTRAR DATE NOV 6 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Knaus			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

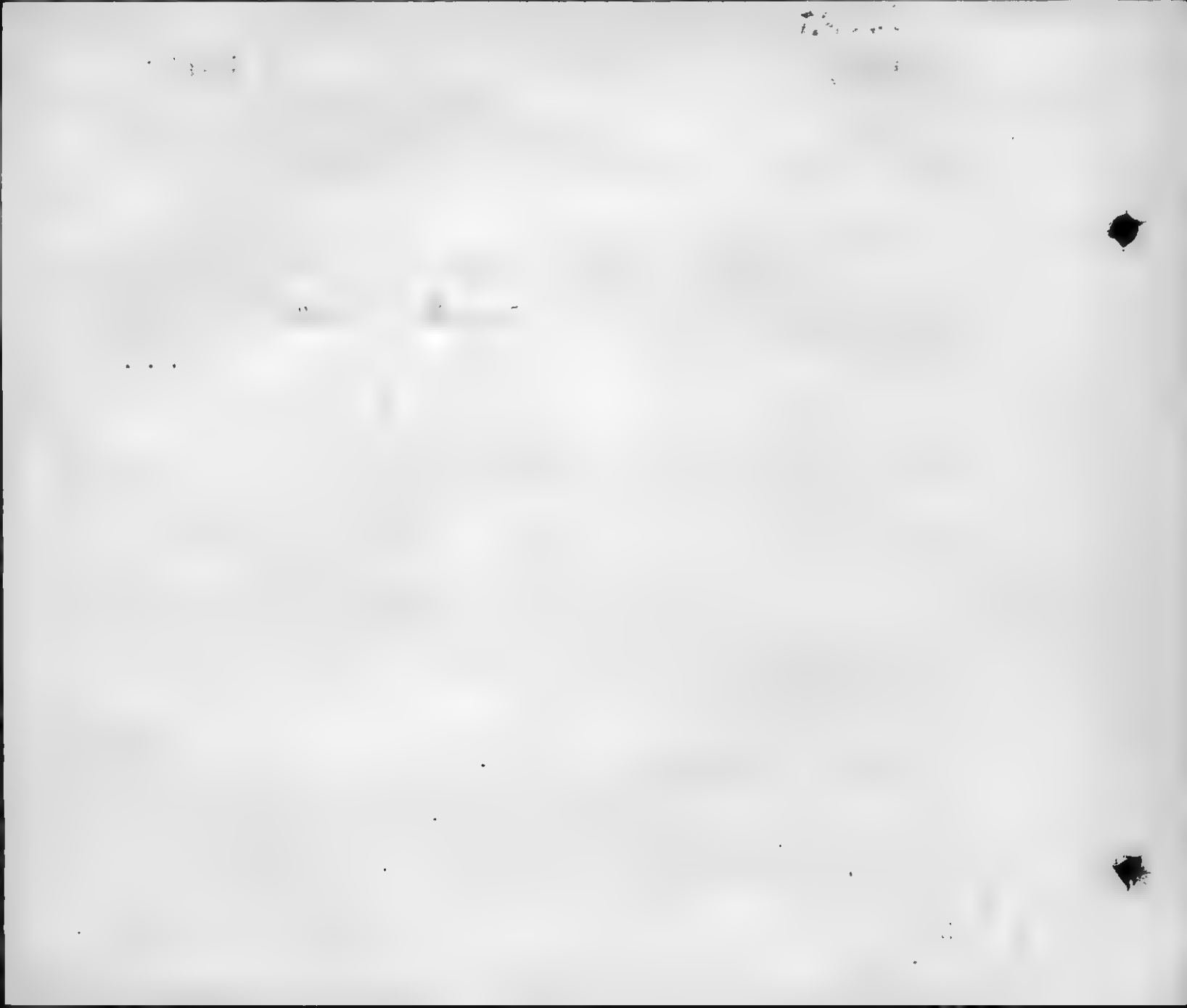
CERTIFICATE OF DEATH

12124

Items 8 & 9 fill in 11/22/61 jwk

12111

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> <u>11 DAYS</u> c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ALLEGANY</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> d. STREET ADDRESS <u>237 COLUMBIA STREET</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MATILDA</u> <u>SOPHIA</u> <u>RICE</u> First Middle Last 4. DATE OF DEATH <u>11</u> <u>12</u> <u>1961</u> Month Day Year		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10/14/84</u> <u>1888</u> <u>73</u> <u>yr.</u> FEMALE WHITE WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-KEEPER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u> 11. BIRTHPLACE <u>WEST VIRGINIA</u> (County & State of foreign country) 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>ROBERT LEE JOHNSON</u> 14. MOTHER'S MAIDEN NAME <u>REBECCA SNYDER JOHNSON</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>CHART</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Acute Gastric Distention</u> DUE TO (c) <u>Gross Negative Bacteremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		INTERVAL BETWEEN ONSET AND DEATH <u>unk</u> <u>unk</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/15/61</u> to <u>11/15/61</u> that (I) (we) last saw the deceased alive on <u>11/15/61</u> and that death occurred at <u>11/15/61</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>DR. MICHAEL L GLICK</u> M.D.		22b. DATE SIGNED <u>11-13-61</u> 22c. PHYSICIAN'S NAME (Type or print) <u>DR. MICHAEL L GLICK</u> 22d. ADDRESS <u>126 N. SMALLWOOD STREET</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11/15/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Lawn Memorial Park</u> 23d. LOCATION (City, town or county) <u>Cumberland</u> (State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth E. Silcox</u> ADDRESS <u>Cumberland Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 15 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 7, MARYLAND

CERTIFICATE OF DEATH

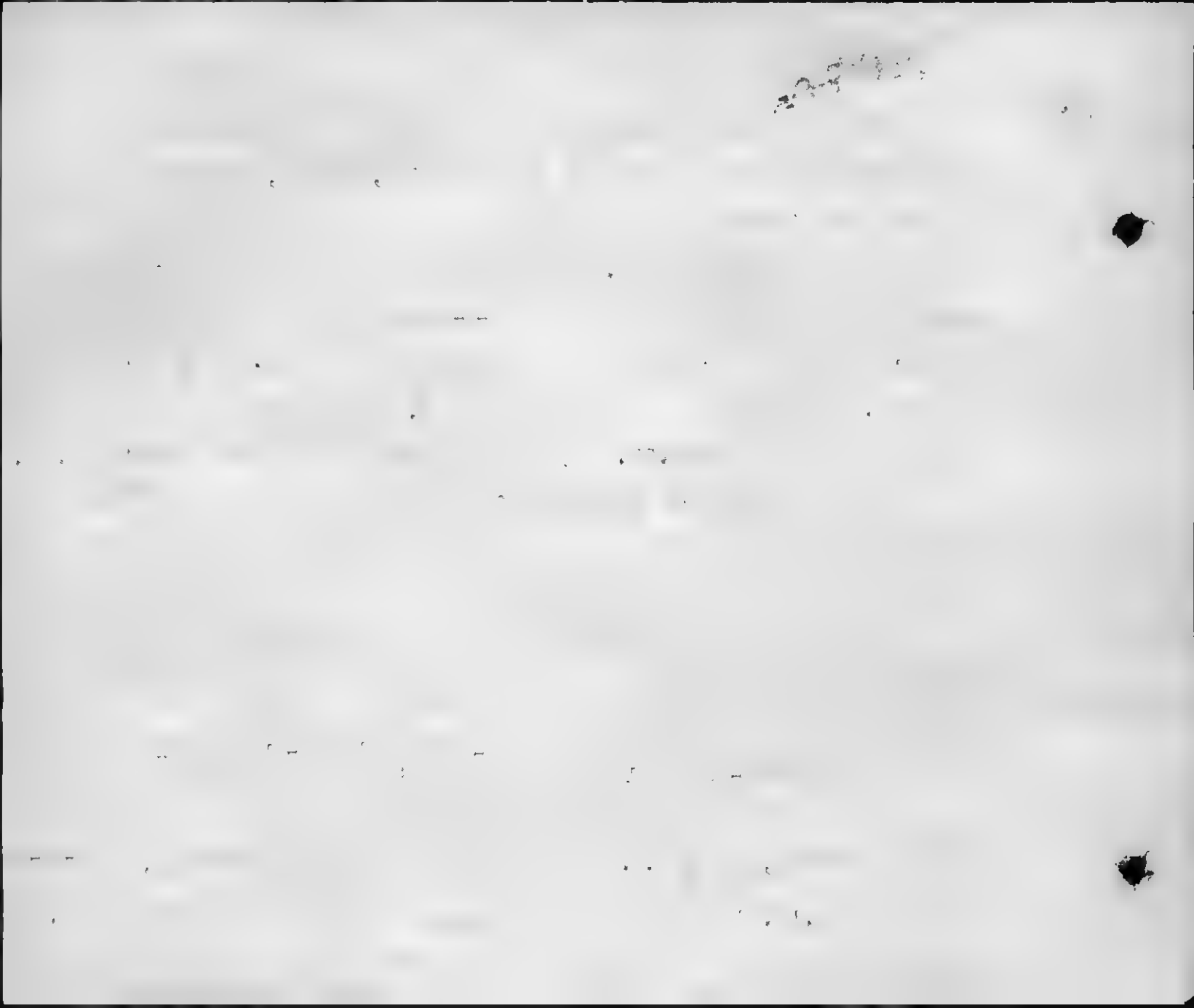
12125

12112

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND MARYLAND c. LENGTH OF STAY (In days) ONE DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution's residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOX 165, HANCOCK, MARYLAND d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First EMORY Middle E. Last ROBINETTE		4. DATE OF DEATH Month 11 Day 19 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-4-1893			
9. AGE (In years last birthday) 68 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labo Mines			
11. BIRTHPLACE (County & State, or foreign country) Allegany County Md.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES			
13. FATHER'S NAME HENRY H. ROBINETTE (D)		14. MOTHER'S MAIDEN NAME JANE E. ROBINETTE (D)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 232226-5899			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-28-61 to 11-11-61, that (I) (we) last saw the deceased alive on 11-11-61, and that death occurred on 11-11-61 from the causes and on the date stated above.					
22a. SIGNATURE <i>Ralph W. Ballin</i>		22b. DATE SIGNED 11-13-61			
22c. PHYSICIAN'S NAME (Type) RALPH W. BALLIN M.D.		22d. ADDRESS 62 GREENE STREET CUMBERLAND, MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11.15.61			
23c. NAME OF CEMETERY OR CREMATORY Buck Valley Christian		23d. LOCATION (City, town or county) (State) Buck Valley Fulton Penn.			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Howard J. Glover</i>		25a. REC'D BY REGISTRAR NOV 16 '61			
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

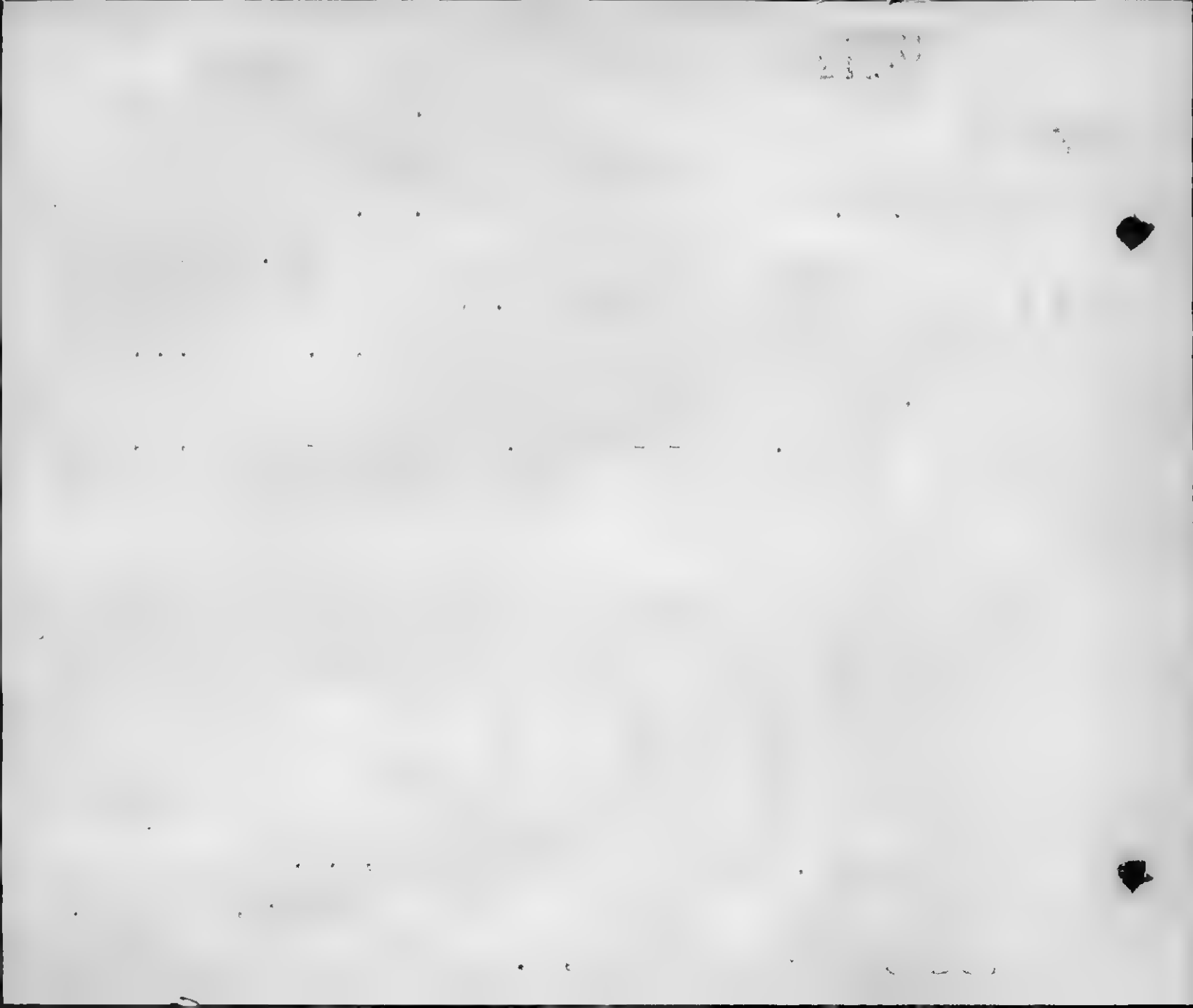
CERTIFICATE OF DEATH

12126

12113

1. PLACE OF DEATH a. COUNTY Allegany b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westernport c. LENGTH OF STAY IN (b) 10 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 324 Md. Ave.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport d. STREET ADDRESS 324 Md. Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles Edward Ross		4. DATE OF DEATH Month Nov. Day 14 Year 1961		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 7, 1872		9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (County & State, or foreign country) Westernport, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James O. Ross		14. MOTHER'S MAIDEN NAME Margaret Guy	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 211-09-0913A		17. INFORMANT Mrs. Marie Lancaster-Winchester, Va.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Degeneration of heart muscle DUE TO (b) chronic Myocarditis and Myocardial DUE TO (c) Degeneration Not Specified as Rheumatic				INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10, 1957 to Nov. 14, 1961 , that (I) (we) last saw the deceased alive on Nov. 10, 1961 , and that death occurred at 5 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Paul R. Wilson		22b. DATE SIGNED Nov. 15, 1961		22c. PHYSICIAN'S NAME (Type) Paul R. Wilson		22d. ADDRESS Piedmont, W. Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/ /61		23c. NAME OF CEMETERY OR CREMATORY Philos		23d. LOCATION (City, town or county) (State) Westernport, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE E. L. Boal		ADDRESS Westernport, Md.		25a. REC'D BY REGISTRAR NOV 17 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

VR A15 (4)
15M 9/60

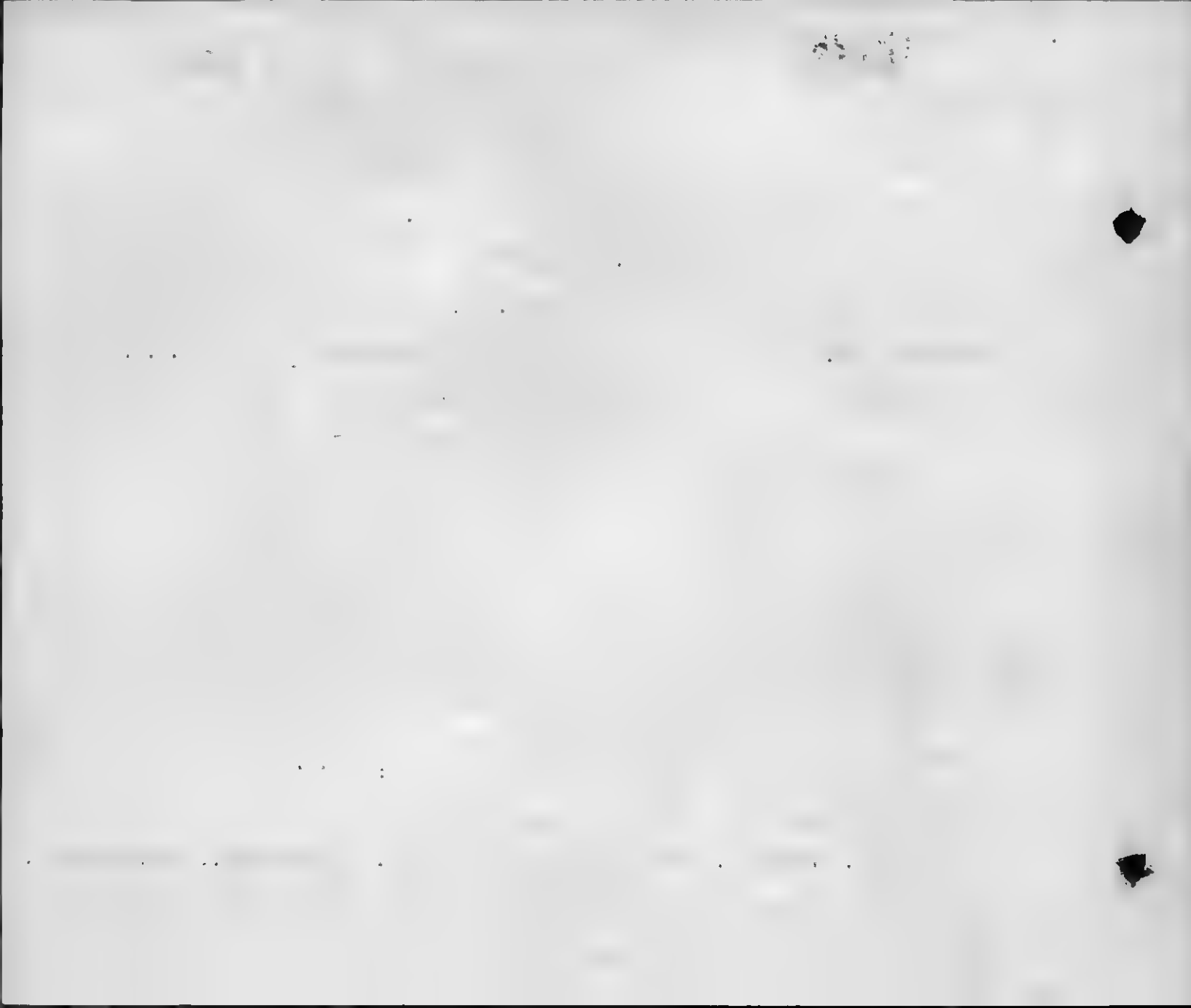


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12128 CERTIFICATE OF DEATH 12115									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN b 31 HRS. 5 MIN d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MEMORIAL HOSPITAL					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town, d. STREET ADDRESS RT. 1, RIDGELEY, W.VA.				
3. NAME OF DECEASED (Type or print) First Middle Last LOIS ANN SELF					4. DATE OF DEATH Month Day Year NOV. 8 1961				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 7, 1961		9. AGE (In years last birthday) yrs 1 IF UNDER 1 YEAR: Months 1 Days 7 IF UNDER 24 HRS.: Hours 5 Min. 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE					10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MARYLAND		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		
13. FATHER'S NAME FLOYD G. SELF					14. MOTHER'S MAIDEN NAME LETHA M. ABE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO None		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7c1-5 DUE TO Previabile Prematurity Abruptio Placenta Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH 31 hrs				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 7 Nov 1961 to 8 Nov 1961 , that (I) (we) last saw the deceased alive on 8 Nov 1961 , and that death occurred 12:00 NOON from the causes and on the date stated above.									
22a. SIGNATURE Leland B. Ransom					22b. DATE SIGNED 9 Nov 61				
22c. PHYSICIAN'S NAME (Type) LELAND B. RANSOM					22d. ADDRESS 63 GREENE ST., CUMBERLAND, MD.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/9/61		23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery		23d. LOCATION (City, town or county) (State) Fort Ashby, W. Va.			
24. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.					25a. REC'D BY REGISTRAR NOV 10 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Huns		

VR A15 (4)
15M 9/60

1924

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12129
CERTIFICATE OF DEATH
12116

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3/10/1961	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) First Middle Last William Holloway Shaw		4. DATE OF DEATH Month Day Year November 13, 1961	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/1877
9. AGE (In years last birthday) 84 yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Store Keeper- Railroad		10b. KIND OF BUSINESS OR INDUSTRY B. & O.	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Shaw		14. MOTHER'S MAIDEN NAME Mary Heavner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. A594502	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension, Chn. degeneration 260X DUE TO Conditions, if any which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/10/61 to 11/13/61 , 19____, that (I) (we) last saw the deceased alive on 11/13/61 at 5:00 P.M. and that death occurred at ____ M., from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 11/14/1961	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF NOV. 16, 1961	
23c. NAME OF CEMETERY OR CREMATORY ST. LUKE'S CEMETERY		23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR NOV 17 '61	
ADDRESS CUMBERLAND, MD.		25b. REGISTRAR'S SIGNATURE Wm. D. Kiser	



FOR STATE
HEALTH DEPT.

M

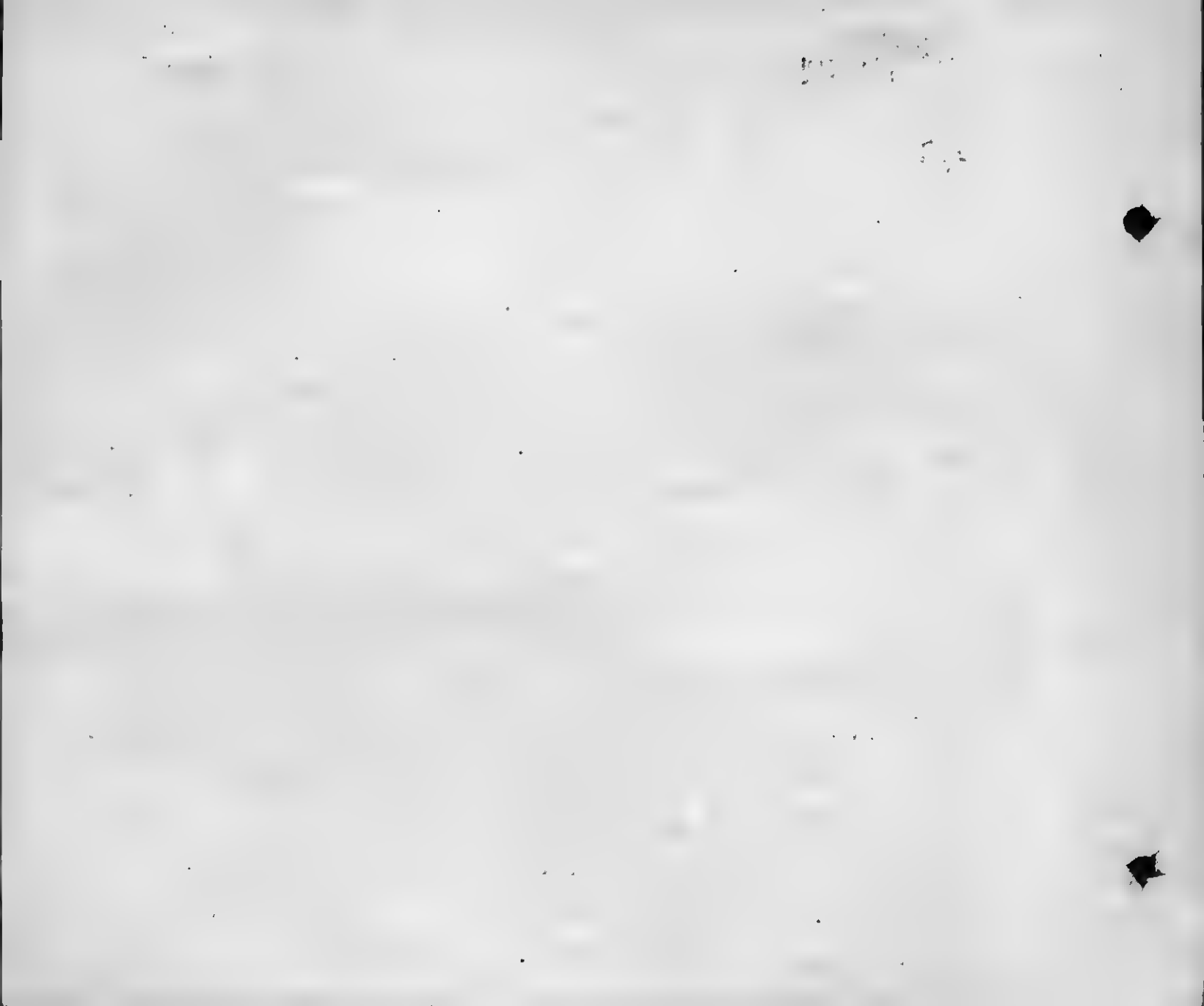
TO DEPT. OF STATE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the State Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

12130
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12117

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>742 Maryland Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Harvey</u> Last <u>Shoemaker</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>13</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 10, 1888</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Mins. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Custodian</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Savings Bank</u>			
11. BIRTHPLACE (State or foreign country) <u>Somerset, Penna.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>George T. Shoemaker</u>				14. MOTHER'S MAIDEN NAME <u>Anna Jane Baer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>War I</u> <u>War I</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Maude Dolan, Cumberland, Md.</u>				Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Delirium Tremens</u> <u>2X</u> DUE TO Conditions, if any, which gave rise to immediate (b) <u>(ALCOHOL, also incident to fractured pelvis sustained when struck by car)</u> (a), stating the underlying (c) <u> </u> lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Struck by automobile</u>							
20c. TIME OF INJURY Hour <u>7:00</u> <u>p.m.</u> Month <u>Nov.</u> Day <u>8</u> Year <u>19 61</u>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u>				20f. (City or town) <u>Cumberland, Alleg. Md.</u> (County) <u> </u> (State) <u> </u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 13, 1961							
Address (Street, city, town, or county) <u>Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>							
22b. DATE THEREOF <u>Nov. 16, 1961</u>							
22c. NAME OF CEMETERY OR CREMATORY <u>Oliver Grove Cemetery</u>							
22d. LOCATION (City, town, or country) (State) <u>Oldtown, Md.</u>							
23. FUNERAL DIRECTOR <u>James F. Scarpelli, Cumberland, Md.</u>							
24a. REC'D BY REGISTRAR <u>NOV 15 '61</u>							
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>							



2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12132

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12119

1 PLACE OF DEATH a. COUNTY Allegany MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b 85yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION East Main Street		e. STREET ADDRESS East Main Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) ANDREW M. SMITH		4. DATE OF DEATH 11/11/1961	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/3/1876	
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant		10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Smith		14. MOTHER'S MAIDEN NAME Elizabeth Merton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. Miss Helen Smith, Lonaconing, MD.	
17. INFORMANT (Daughter)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO myocardial ischemia, atrial fibrillation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic coronary artery disease DUE TO years (c)		INTERVAL BETWEEN ONSET AND DEATH 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Adenocarcinoma of Colon		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21 I certify that (I) (this hospital) attended the deceased from Mar. 1956 to Nov. 11, 1961 , that (I) (we) last saw the deceased alive on 11-9-1961 , and that death occurred at 1 P.M. from the causes and on the date stated above			
22a. SIGNATURE [Signature] M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 11-13-61	
22c. PHYSICIAN'S NAME (Type) L.R. MILES, JR., M.D.		22d. ADDRESS LONACONING, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Cumberland, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN ADDRESS LONACONING, MD.		25a. REC'D BY REGISTRAR NOV 15 '61	
		25b. REGISTRAR'S SIGNATURE Cynthia S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

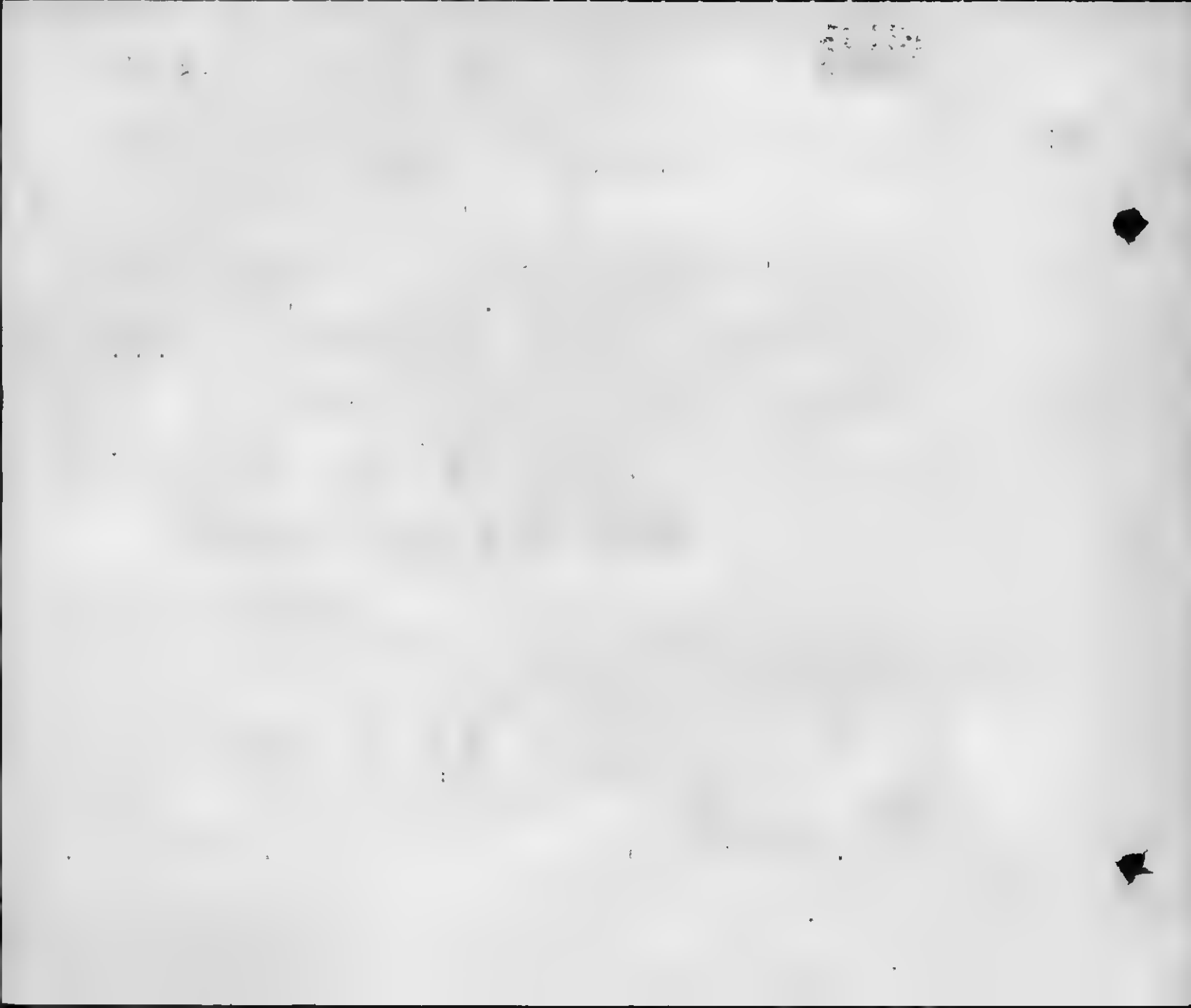
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12133

12120

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MEMORIAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 128 SPRINGDALE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ALICE E SNOEBERGER		4. DATE OF DEATH Month NOVEMBER Day 22 Year 19 61		5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> SEPT. 28, 1890		9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor 10b. KIND OF BUSINESS OR INDUSTRY Textile Industry 11. BIRTHPLACE (County & State, or foreign country) MARYLAND BROWNESVILLE 12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME HENRY FEASTER 14. MOTHER'S MAIDEN NAME JENNIE PHILLIPS							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. 212-24-1809 17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MD.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Coronary Heart Failure - Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Arteriosclerosis (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (i) (this hospital) attended the deceased from Aug. 19, 60 to Nov. 22, 1961 that (I) (we) last saw the deceased alive on Nov 22, 1961 and that death occurred 11:20 A.M. from the causes and on the date stated above.											
22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type) G. OVERTON HIMMELWRIGHT				22b. DATE SIGNED 22d. ADDRESS 133 VIRGINIA AVE., CUMBERLAND, MD.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 25, 1961		23c. NAME OF CEMETERY OR CREMATORY Old Church of Brethren		23d. LOCATION (City, town or county) (State) Brownsville, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR NOV 28 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Thomas</i>					

MEDICAL CERTIFICATION



1
FOR STATE
HEALTH DEPT.

M

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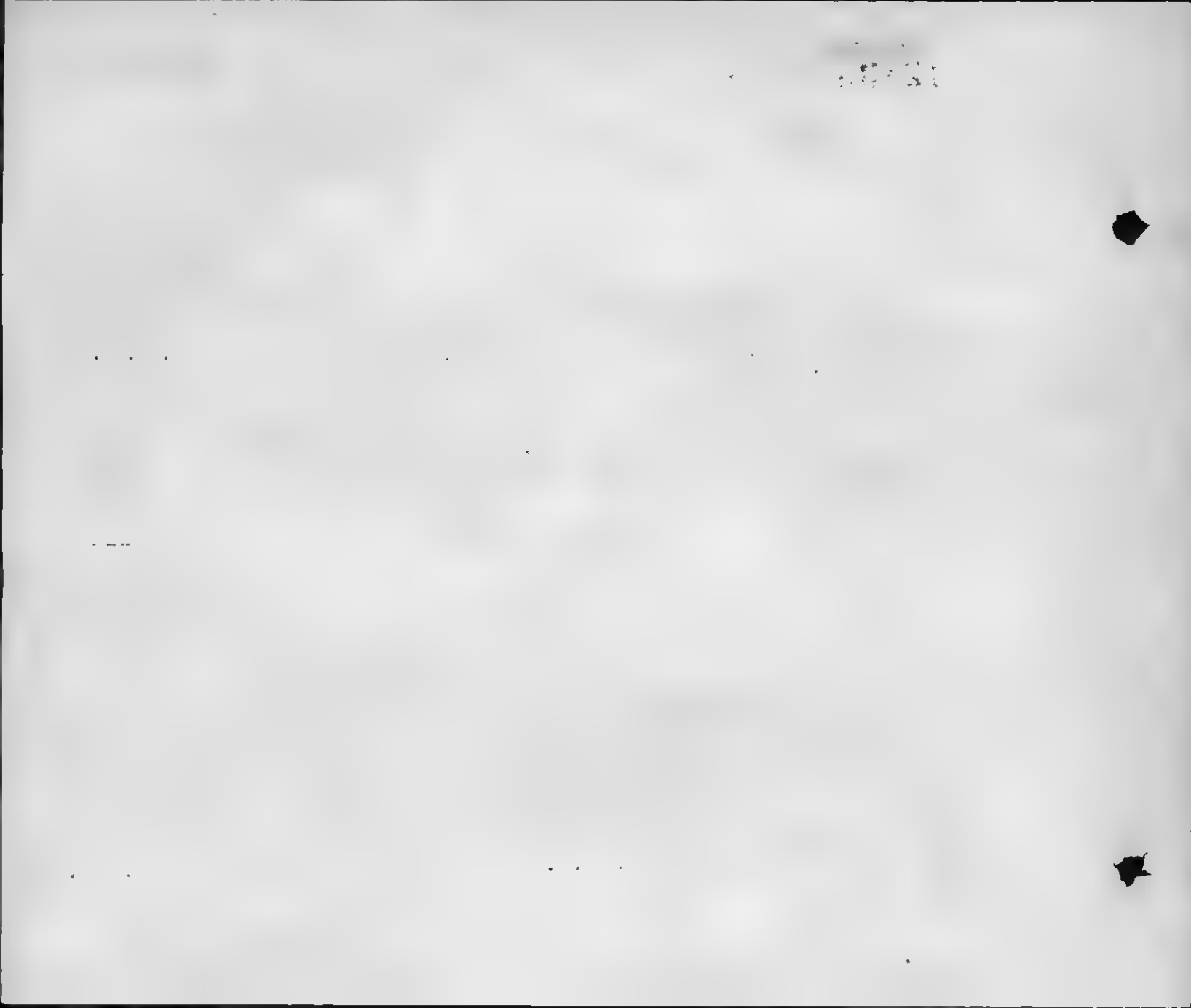
VS. A15ME
SM 9/60

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission)			
a. COUNTY				a. STATE			
Allegany				West Virginia			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
Cumberland				Van			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
Memorial Hospital							
3. NAME OF DECEASED (Type or print)			4. DATE OF DEATH			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
First Middle Last			Month Day Year				
Frank Snyder			November 12			19 61	
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (in years last birthday)		10. IF UNDER 1 YEAR
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	October 8, 1893		68 yrs.		Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Retired coal miner		W Va		Lopez, Pennsylvania		U. S. A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
William Snyder (Deceased)				Tillie Mechtas (Deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address	
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>		WW I 236-09-2396		Mrs. Rhode Snyder		Van, West Virginia	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:				CORONARY OCCLUSION			
IMMEDIATE CAUSE (a)				DUE TO			
420.1				(b)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				CORONARY SCLEROSIS			
(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
19							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER		DATE SIGNED	
Benedict Skitarelic				M.D.		November 12, 1961	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER		Cumberland, Md.	
BENEDICT SKITARELIC, M.D.				Address (Street, city, town, or country)			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or country) (State)	
Burial		11/15/61		Memory Gardens Cemetery		Madison West Virginia	
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE			
Ruth E. Silcox Cumberland Maryland				NOV 14 '61			

Christina L. Plante



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, Page 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9 60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12135 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12122

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institutional, Residence before admission) a. STATE <u>PENNSYLVANIA</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CLAYSVILLE</u>	
c. LENGTH OF STAY IN 1b <u>10 Hrs.</u>		d. STREET ADDRESS <u>219 1/2 Wayne Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ALFRED J. SPOSSY</u>		4. DATE OF DEATH <u>November 18 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 25, 1913</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>	
13. FATHER'S NAME <u>Anthony Spossey</u>		14. MOTHER'S MAIDEN NAME <u>Rose Glemma</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>191-03-4514</u>	
17. INFORMANT <u>MEMORIAL HOSPITAL, CUMBERLAND, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTRACRANIAL HEMORRHAGE</u> 825X DUE TO Conditions, if any which gave rise to immediate cause (b) <u>SKULL FRACTURE</u> (a), stating the underlying cause last. DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (e) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile accident</u>	
20c. TIME OF INJURY <u>3:00 a.m. Nov. 18 19 61</u>		20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 28</u>		20f. (City or town) <u>5 Miles South Ridgeley, Min. W. VA.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Benedict Skitarelic</u>		DATE SIGNED <u>November 18, 1961</u>	
EXAMINER'S NAME (Type) <u>BENEDICT SKITARELIC, M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/22/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Immaculate Conception</u>		22d. LOCATION (City, town, or country) <u>Washington Penna</u>	
23. FUNERAL DIRECTOR <u>Robert J. Abel</u>		24a. REC'D BY REGISTRAR <u>NOV 22 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Washington, Penna</u>		24c. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

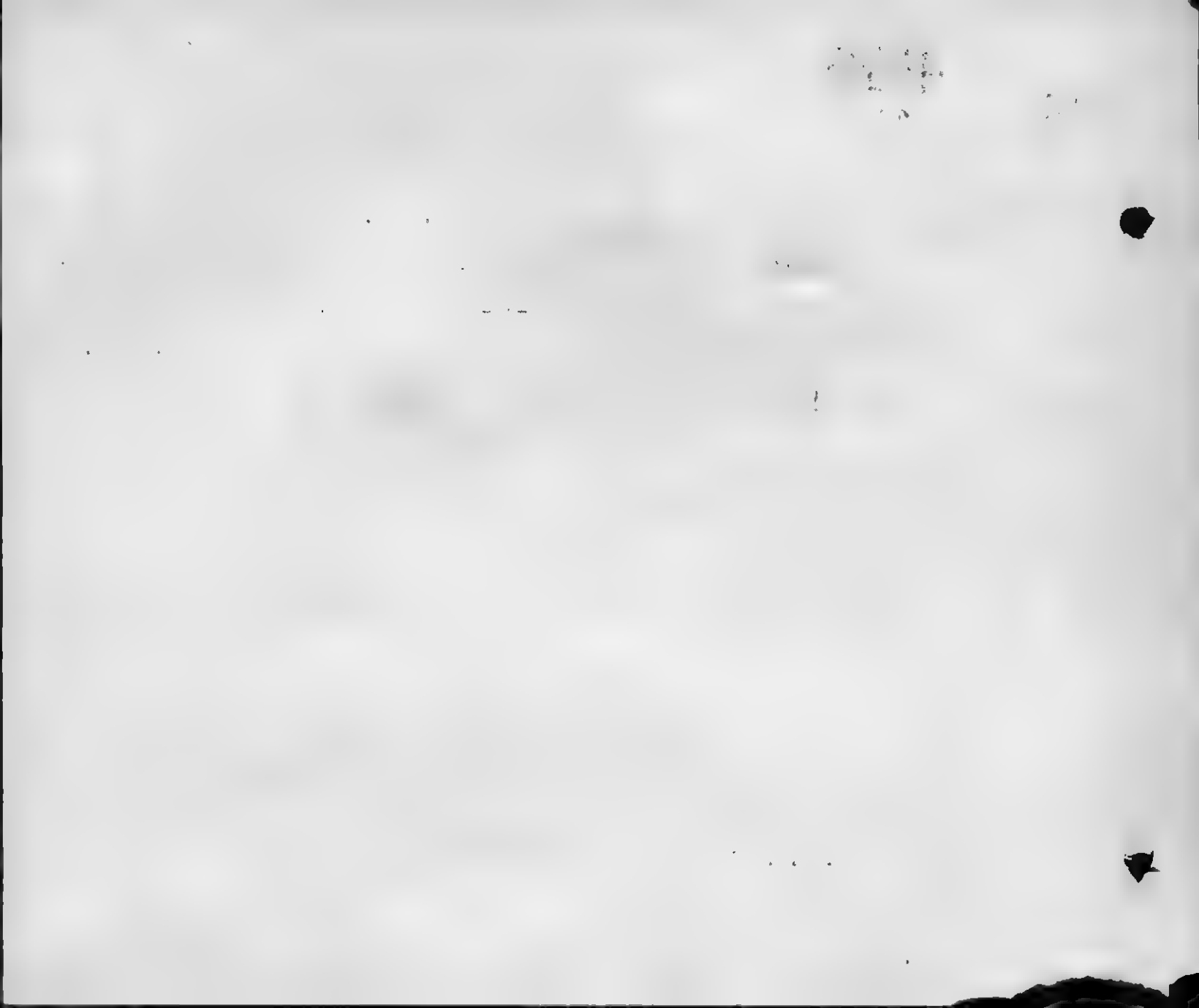


1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12136 CERTIFICATE OF DEATH 12123															
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 3 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SACRED HEART HOSPITAL						2. USUAL RESIDENCE (Where deceased lived, if last 12 months; Residence before admission) a. STATE MARYLAND ALLEGANY b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 200 N. AVE. POTOMAC PARK e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) DIETER SROKOSIK		4. DATE OF DEATH NOV 2 1961		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-30-46					
9. AGE (In years last birthday) 15 yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months Days</td> <td>Hours Min.</td> </tr> </table>				IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months Days	Hours Min.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STUDENT				10b. KIND OF BUSINESS OR INDUSTRY			
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months Days	Hours Min.														
11. BIRTHPLACE (County & State, or foreign country) GERMANY				12. CITIZEN OF WHAT COUNTRY? U. S. A.											
13. FATHER'S NAME GEORGE SROKOSIK						14. MOTHER'S MAIDEN NAME KATHE WOHLERS									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. NONE									
17. INFORMANT PT'S CHART						Address									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 1.0 LYMPHATIC LEUKEMIA CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (b) (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Aug 1, 1961 to Nov 2, 1961 that (I) (we) last saw the deceased alive on Nov 2, 1961 and that death occurred at 11:00 A.M. from the causes and on the date stated above.															
22a. SIGNATURE DR. B.M. SCHINDLER						22b. DATE SIGNED 11/5/61									
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS 43 GREENE STREET									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/6/61		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		23d. LOCATION (City, town or county) Cumberland		(State) Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox						25a. REC'D BY REGISTRAR DATE NOV 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Evans							



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a day is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

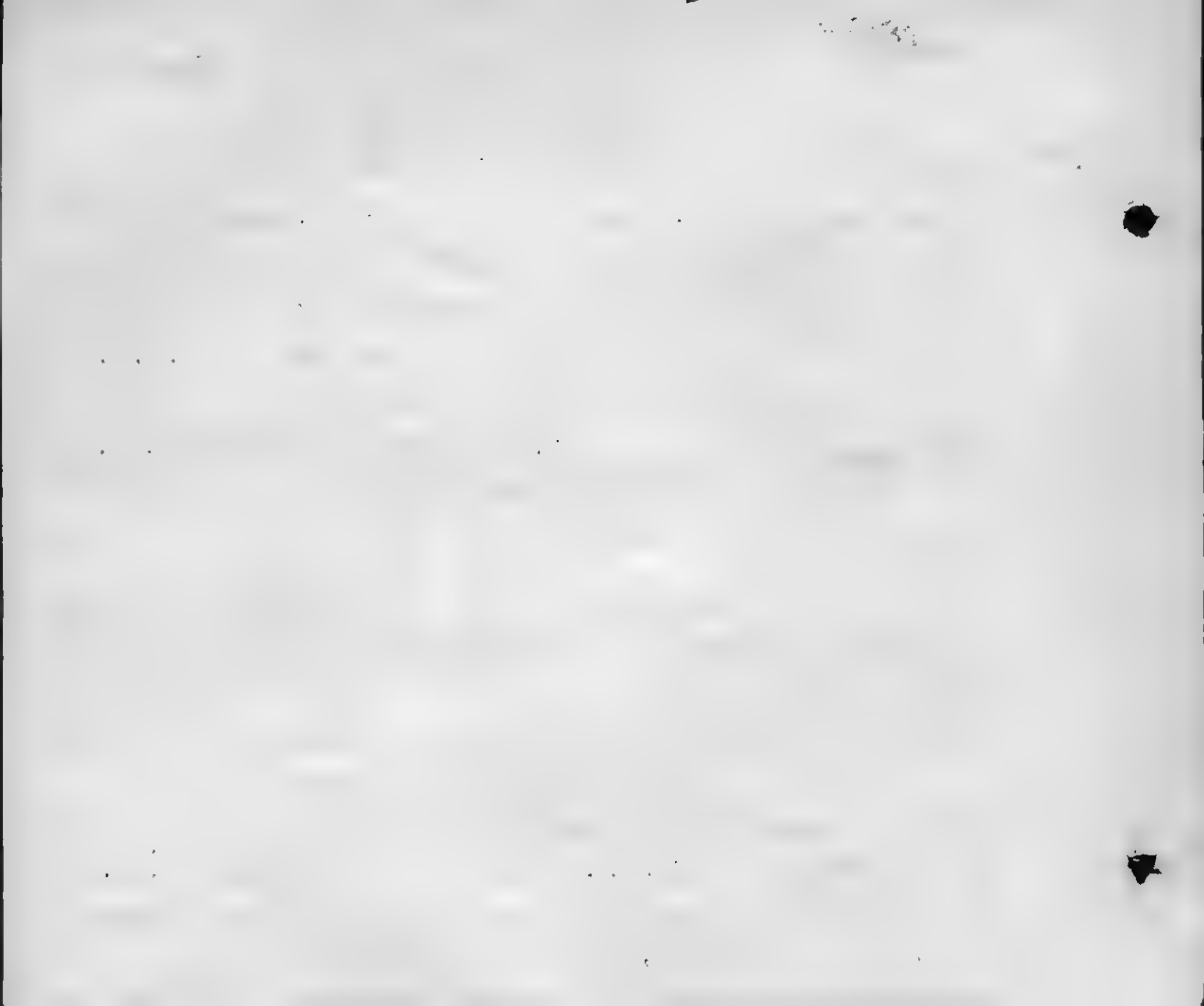
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND

12137

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12124

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institutional; Residence before admission) a. STATE MARYLAND				b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Winchester Road, Cresaptown, Maryland				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Ida Elizabeth Staggs				4. DATE OF DEATH November 11 19 61							
5. SEX FEMALE				6. COLOR OR RACE WHITE				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH 10/28/875				9. AGE (In years last birthday) 86 yrs.				10. F UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Cresaptown, Maryland			
12. CITIZEN OF WHAT COUNTRY? U. S. A.				13. FATHER'S NAME Isaac Dawson				14. MOTHER'S M A DEN NAME Emily Dawson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Mr. Jackson Staggs (son)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 420.1 DUE TO CORONARY OCCLUSION Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO CORONARY SCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH SUDDEN				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 11, 1961											
Address (Street, city, town, or county) Cumberland, Md.											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF 11/13/61											
22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park											
22d. LOCATION (city, town, or county) Cumberland Allegany County Maryland											
23. FUNERAL DIRECTOR John J. Hafer											
24a. REC'D BY REGISTRAR NOV 16 '61											
24b. REGISTRAR'S SIGNATURE Arthur L. Hafer											

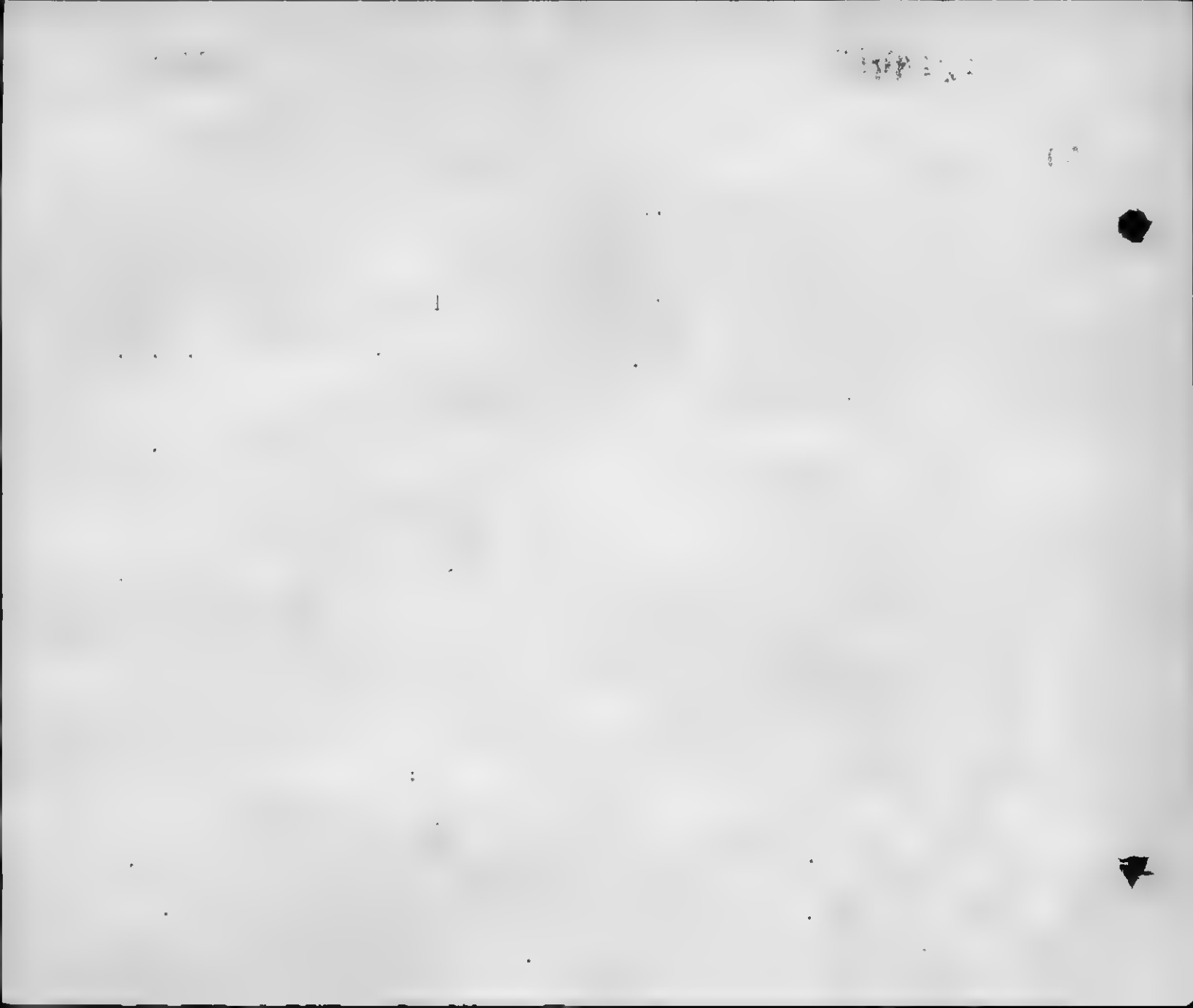


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11-21-61
12138
M

I

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND											
CERTIFICATE OF DEATH											
12125											
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN b 12 HOURS d. NAME OF HOSPITAL OR INSTITUTION (If outside corporate limits, write RURAL and give nearest town) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.,						2. USUAL RESIDENCE (Where deceased lived, if institution on, Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 322 RACE STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First CHARLES Middle EDWARD Last STURTZ						4. DATE OF DEATH Month NOVEMBER Day 10 Year 1961					
5. SEX MALE						6. COLOR OR RACE WHITE					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH JULY 3, 1924					
9. AGE (In years if UNDER 1 YEAR, last birthday) 37 yrs.						10. AGE (In years if UNDER 24 HRS., last birthday) 37 yrs.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Room Worker						10b. KIND OF BUSINESS OR INDUSTRY KELLY SPRINGFIELD TIRE					
11. BIRTHPLACE (County & State, or foreign country) MARYLAND, CUMBERLAND						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME CHARLES STURTZ						14. MOTHER'S MAIDEN NAME BOGGS, BESSIE					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO 219-14-5794					
17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4331 Arrhythmic fibrillation and DUE TO circulatory failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Rectal bleeding (Cause undetermined) DUE TO R/K PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 6 months											
INTERVAL BETWEEN ONSET AND DEATH 24 hours											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 11/11/61 to 11/11/61 19 61 , that (I) (we) last saw the deceased alive on 11/11/61 19 61 , and that death occurred 8:10 A.M. from the causes and on the date stated above.											
22a. SIGNATURE DR. GEORGE SIMONS M.D.											
22b. DATE SIGNED NOV 15 '61											
22c. PHYSICIAN'S NAME (Type) DR. GEORGE SIMONS											
22d. ADDRESS ALGONQUIN HOTEL, CUMBERLAND, MARYLAND											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF Nov. 13, 1961											
23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park											
23d. LOCATION (City, town or county) (State) Cumberland, Md.											
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.											
25a. REC'D BY REGISTRAR NOV 15 '61											
25b. REGISTRAR'S SIGNATURE Arthur S. Hines											



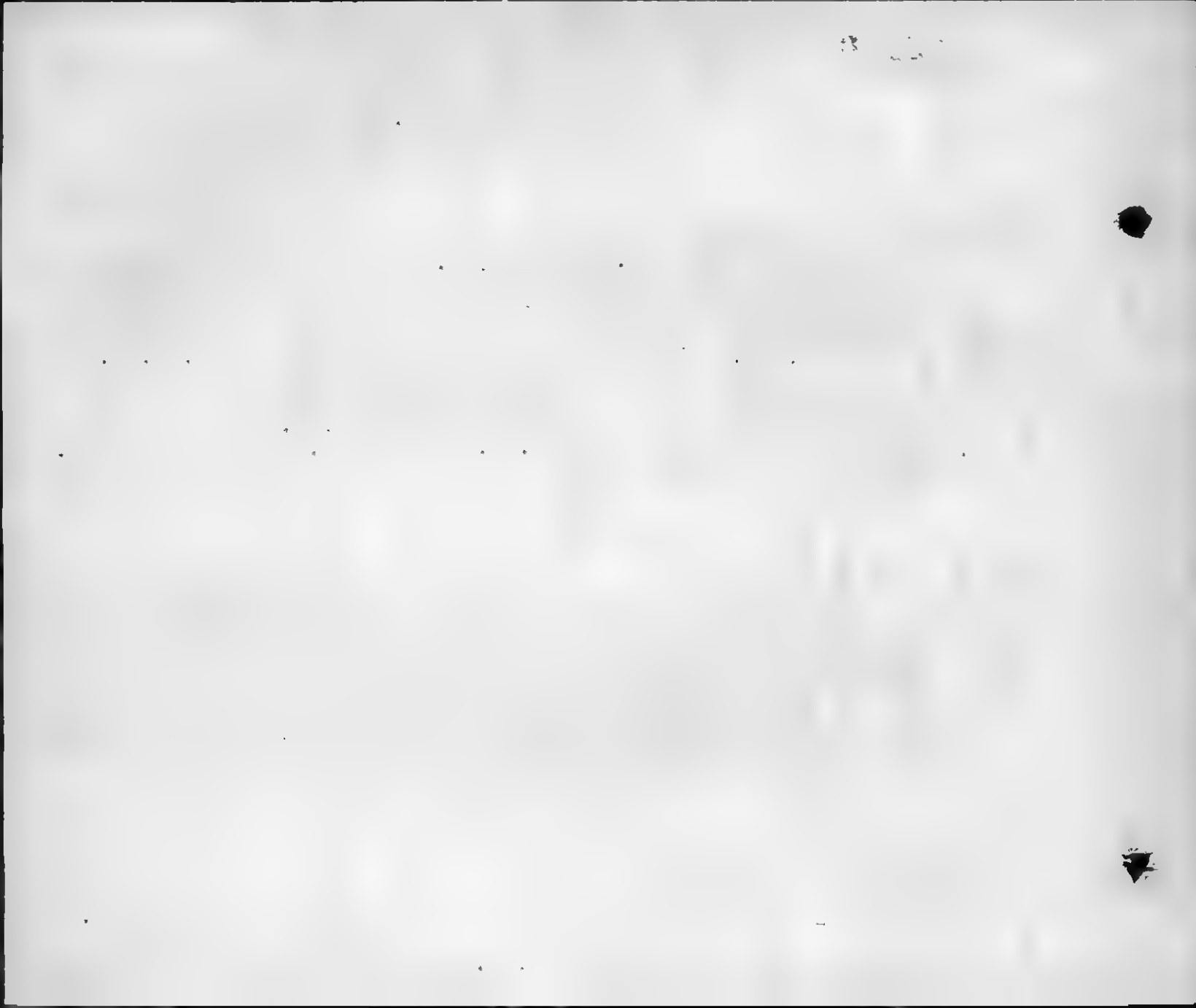
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12139

Reg. Dist. No. 12126

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>	
c. LENGTH OF STAY IN 1b <u>Life time</u>		d. STREET ADDRESS <u>221 Center Street</u>	
4. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Braddock Park</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Edward L. Thomas, Sr.</u>		4. DATE OF DEATH Month Day Year <u>11 15 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-21-1905</u>
9. AGE (In years last birthday) <u>56 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. <u>11 15 19 61</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Condition, Dept Celanese Corp</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Frostburg</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Llewellyn Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Ida Sharp</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No.</u>		16. SOCIAL SECURITY NO. <u>214-07-6363</u>	
17. INFORMANT <u>Ed. L. Thomas, Jr.</u>		Address <u>221 1/2 Center St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gun Shot Wound of Brain</u> 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fracture of Base of Brain</u> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in Rt Temple with 22 Revolver.</u>	
20c. TIME OF INJURY Month, Day, Year <u>11-15-1961</u> Hour <u>6:00</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Frostburg</u> (County) <u>Allegany</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>W O McLane</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W O McLane MD asst</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Nov 16 1961</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11-18-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Sun Set Memorial Park</u>	22d. LOCATION (City, town, or county) <u>Cumberland</u> (State) <u>Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u>		24a. REC'D BY REGISTRAR <u>NOV 20 1961</u>	
24b. REGISTRAR'S SIGNATURE <u>W. B. Marshall</u>		24c. REGISTRAR'S SIGNATURE	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

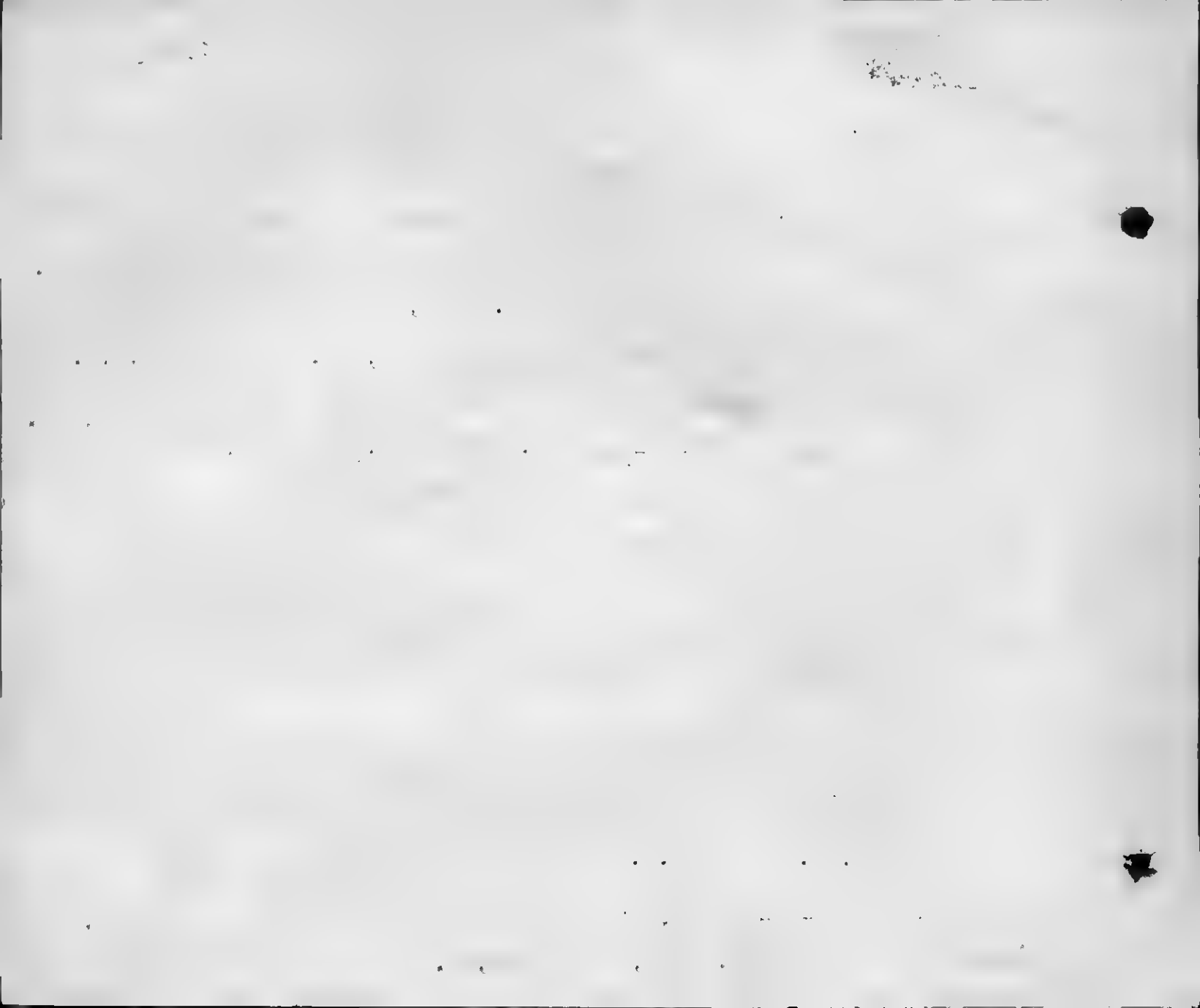
12140

12127

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician for 4 years after the date of death. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> c. LENGTH OF STAY IN 1b <u>Lifetime</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Miners Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u> d. STREET ADDRESS <u>55 West Main Street</u>			
3. NAME OF DECEASED (Type or print) <u>NELLIE</u> <u>JOHNS</u> <u>THOMPSON</u>				4. DATE OF DEATH <u>11</u> <u>20th</u> <u>19</u> <u>61</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 17th, 1893</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Food Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>School Cafeteria Frostburg, Md.</u>			
11. BIRTHPLACE (Country & State, or foreign country)				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Christopher Johns</u>				14. MOTHER'S MAIDEN NAME <u>Mary Carroll</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>212-18-1589</u>			
17. INFORMANT <u>Mr. William J. Thompson, 505 Manor Terrace</u>				Address <u>Harrisburg, Pa.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960-1961</u> , to <u>Nov 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 19, 1961</u> , and that death occurred at <u>4:45</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>W O McLane</u> M.D.				22b. DATE SIGNED <u>Nov 21/1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>W. O. McLane M.D.</u>				22d. ADDRESS <u>Frostburg Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-22-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Michaels Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Frostburg Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Richard H. Winters</u>				25. REC'D BY REGISTRAR <u>Nov 27 '61</u>			
25a. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur E. Harris</u>			

VR A15 (4)
 15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1 **MARYLAND STATE DEPARTMENT OF HEALTH**
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12141

12128

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 9/5/1961	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle Claud Last Turner		4. DATE OF DEATH Month November Day 25 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/15/1893
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired; Machinist Helper Railroad		10b. KIND OF BUSINESS OR INDUSTRY W/Md. Okanoka, Maryland	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Turner		14. MOTHER'S MAIDEN NAME Anna Kerns	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown, If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		18. Allegany County Infirmary records.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, acute DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - Coronary Arteriosclerosis DUE TO (c) Aphasia due to Cerebral Vascular Disease			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/5/1961 to 11/25/1961 , that (I) (we) last saw the deceased alive on 11/25/1961 @ 12:30 P.M. and that death occurred at 11/25/1961 M, from the causes and on the date stated above.			
22a. SIGNATURE Dr. Lee B. Mathews		22b. DATE SIGNED 11/27/61	
22c. PHYSICIAN'S NAME (Type) Dr. Lee B. Mathews		22d. ADDRESS 49 Greene St., Cumberland, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 28, 1961	
23c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Gardens		23d. LOCATION (City, town, or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		25a. REC'D BY REGISTRAR DATE NOV 30 '61	
25b. REGISTRAR'S SIGNATURE Charles E. Rimmer			

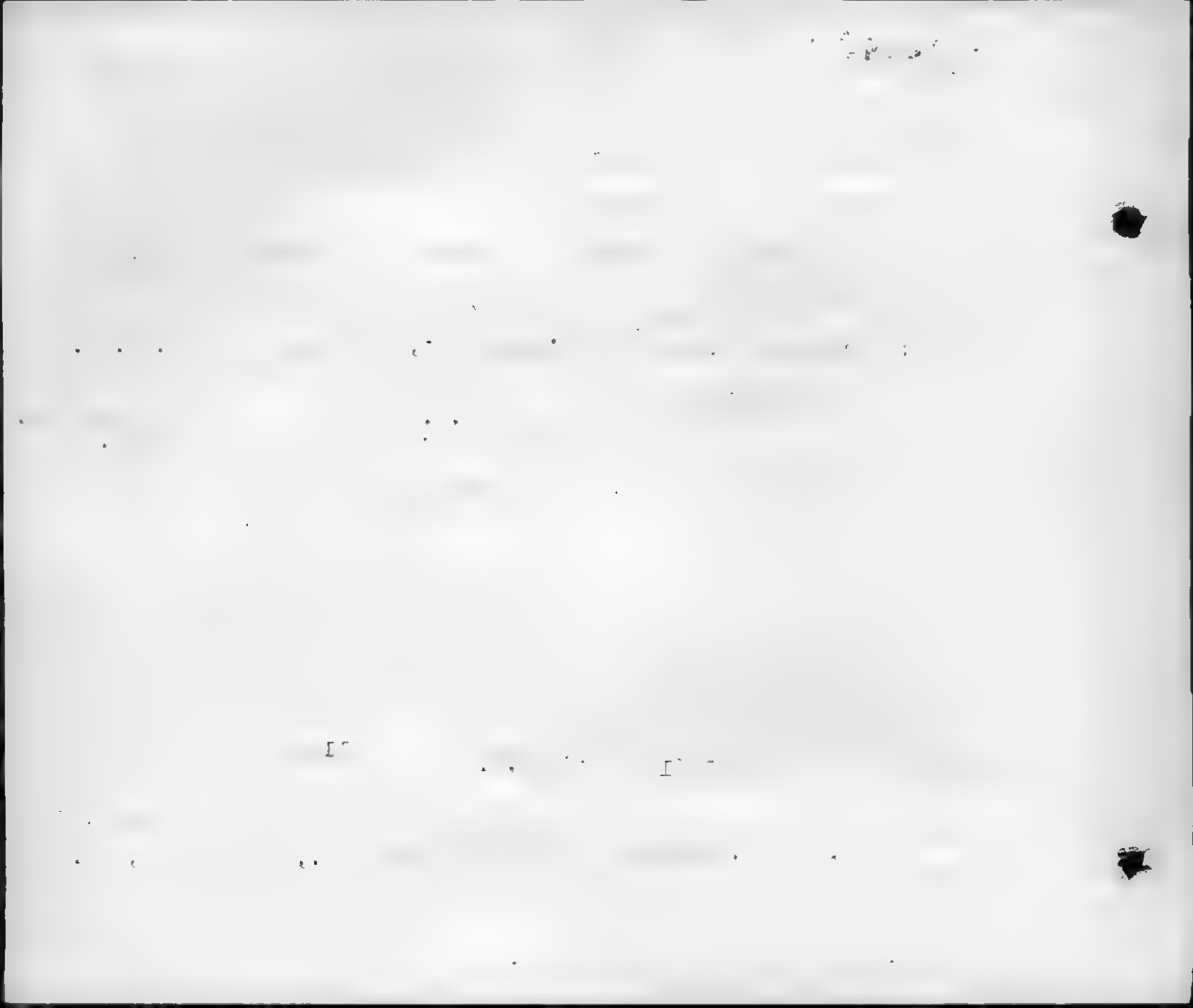
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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

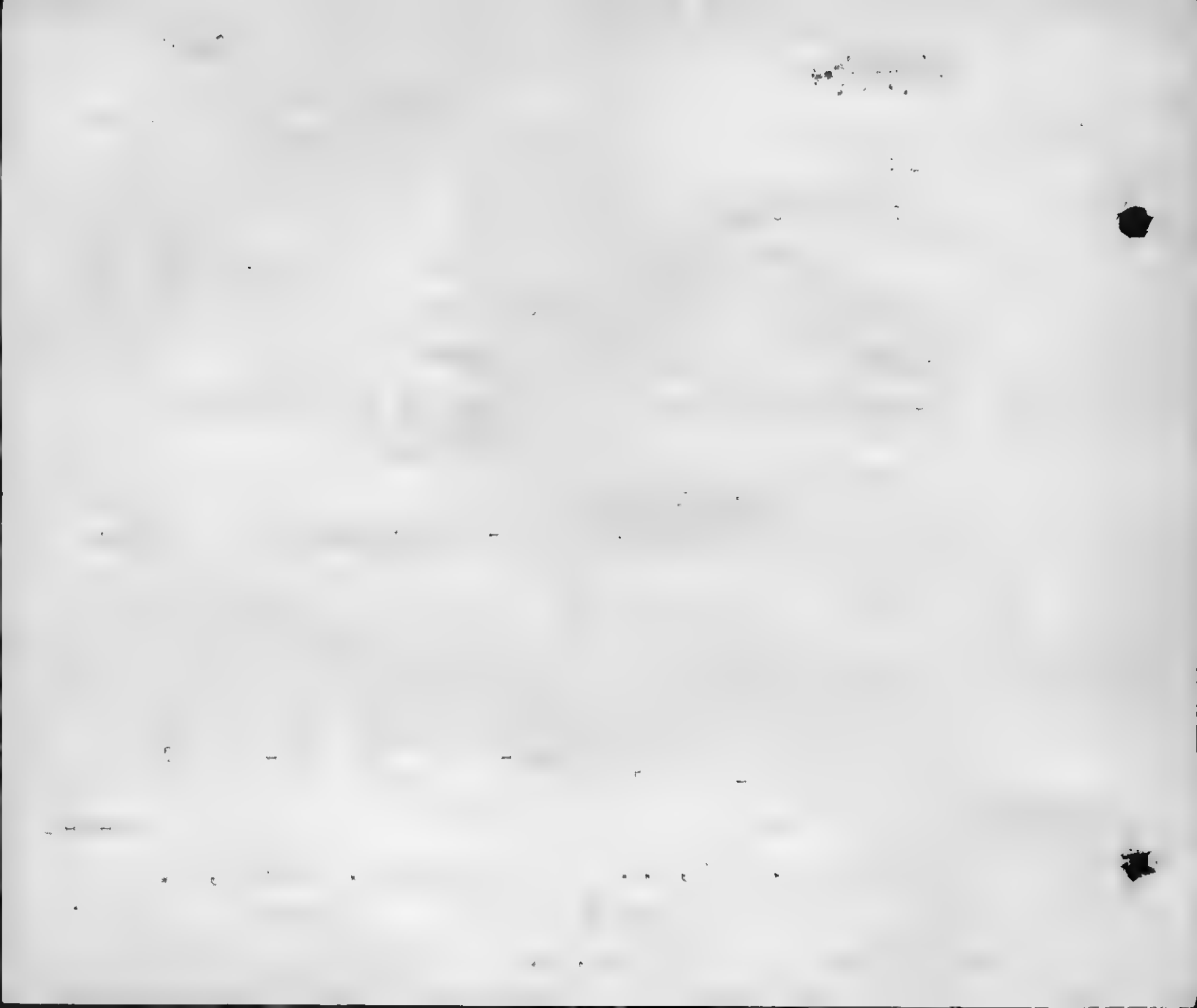
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

Page 4 may be retained by the hospital or attending physician.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filed in by the funeral home, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LUKE	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN		4. DATE OF DEATH Month NOV. Day 11 Year 1961	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 9, 1884	
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR Months 77 Days 77	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN	
13. FATHER'S NAME ISSAC VANMETER (DECEASED)		14. MOTHER'S MAIDEN NAME HANNA McKENZIE (DECEASED)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 1-11-111111	
17. INFORMANT JOHN		18. PATIENTS CHART 11-11-61	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular accident (b) Arteriosclerotic Cardio-vascular disease (c) Due to Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a).	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 11 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 62 Greene St. Cumberland, Md.		20f. (City or town) (County) (State) Westernport Md.	
21. I certify that (I) (this hospital) attended the deceased from 11-11-61 to 11-11-61 , that (I) (we) saw the deceased alive on 11-11-61 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.		22a. SIGNATURE Ralph W. Ballin, M.D.	
22b. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.		22c. DATE 11-11-61	
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF 11/13/61	
23c. NAME OF CEMETERY OR CREMATORY Philos Cem		23d. LOCATION (City, town or county) (State) Westernport Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Huns		25a. REC'D BY REGISTRAR NOV 16 1961	
25b. REGISTRAR'S SIGNATURE Arthur L. Huns		25c. REGISTRAR'S SIGNATURE Arthur L. Huns	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12143

CERTIFICATE OF DEATH

12130

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SACRED HEART HOSPITAL				d. STREET ADDRESS 114 NEW HAMPSHIRE AVE.			
3. NAME OF DECEASED (Type or print) First Middle Last CATHERINE FRANCES WEBER				4. DATE OF DEATH Month Day Year NOVEMBER 15 1961			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 30, 1910	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		9. AGE (In years last birthday) 50 51 yrs.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND CUMBERLAND	
13. FATHER'S NAME JOSEPH WEBER				14. MOTHER'S MAIDEN NAME ANNA LUECK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. 214-05-6785			
17. INFORMANT PATIENT'S CHART				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 11 - 10 , 61 , to 11 - 15 , 61 , that (I) (we) last saw the deceased alive on 11 - 15 , 61 , and that death occurred at 11 AM, from the causes and on the date stated above.							
22a. SIGNATURE Ralph W. Ballin				22b. DATE SIGNED 11-15-61		22c. PHYSICIAN'S NAME (Type) Ralph W. Ballin, M.D.	
22d. ADDRESS 62 Greene St Cumberland, Md.				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 18, 1961		23c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul Cemetery		23d. LOCATION (City, town or county) (State) Cumberland, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. RECORDING REGISTRAR NOV 17 1961		25b. REGISTRAR'S SIGNATURE C. L. & H. Hines	



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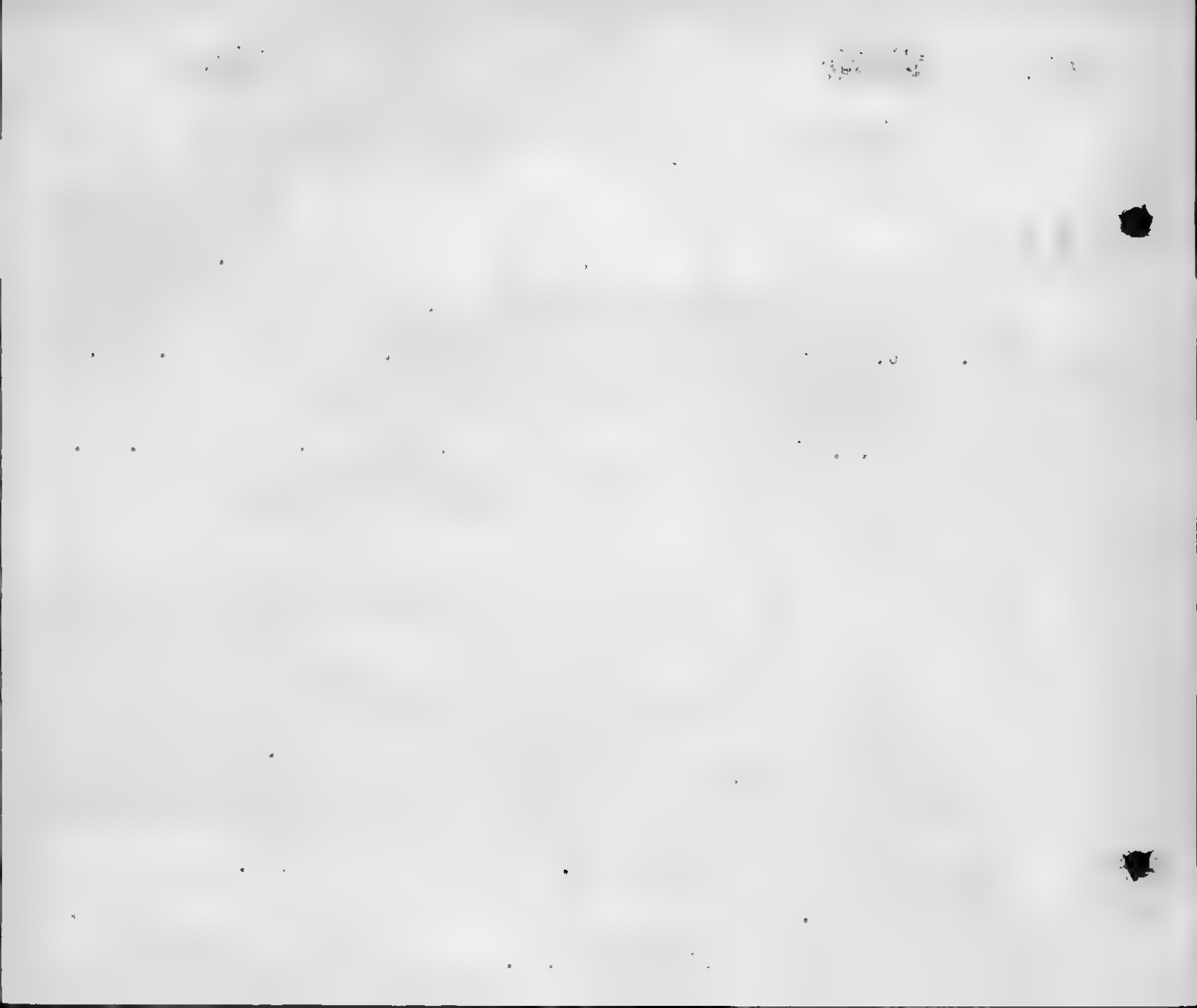
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12131

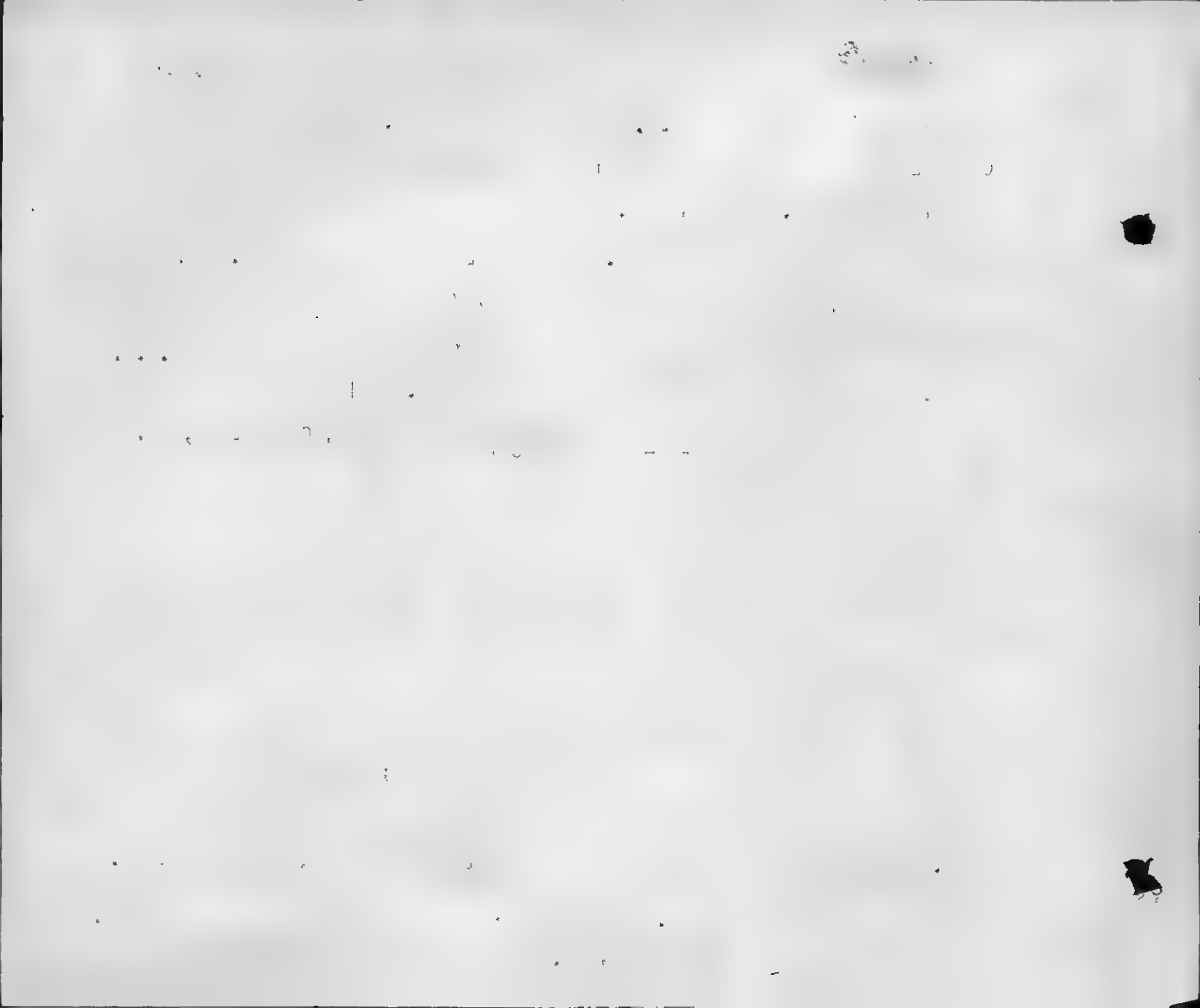
1. PLACE OF DEATH a. COUNTY <u>ALLEGANEY</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LUKE</u> c. LENGTH OF STAY IN 1b <u>3 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>430 PRATT STREET</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>CALIFORNIA</u> b. COUNTY <u>SAN FRANCISCO</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>40X</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE O. WILLIAMS</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>16</u> Year <u>19 61</u>	
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>OCT. 13, 1922</u> 9. AGE (In years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mgr. Dept. Store Macy's</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>LUKE, MD.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>U.S. A.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>George O. Williams</u> 14. MOTHER'S MAIDEN NAME <u>Mammie E. Smith</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> 16. SOCIAL SECURITY NO. <u>W.V. 11</u> 17. INFORMANT <u>Oliver D. Williams, Luke, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>592X</u> IMMEDIATE CAUSE (a) <u>Chronic Glomerular nephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov 4, 1961</u> to <u>Nov 16, 1961</u> that (I) (we) last saw the deceased alive on <u>Nov 16, 1961</u> and that death occurred at <u>11am</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James H. Wolverton Jr.</u>		22b. DATE SIGNED <u>Nov. 17, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>James H. Wolverton Jr.</u>		22d. ADDRESS <u>Piedmont W.Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Philos Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Westernport Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. Fredlock Jr.</u>		25a. REC'D BY REGISTRAR <u>NOV 20 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>W. L. Harts</u>		25c. ADDRESS <u>Piedmont, W.Va.</u>	



VR A15 (4)
15M 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b Memorial Hospital			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Melvin Charles Wright				4. DATE OF DEATH November 7, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 7, 1894	
9. AGE (in years last birthday) 67		10. IF UNDER 1 YEAR Months 7 Days 19		11. IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Train Dispatcher (Ret)				10b. KIND OF BUSINESS OR INDUSTRY Western Md. R.R.			
11. BIRTHPLACE (State or foreign country) Frostburg, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John Wright				14. MOTHER'S MAIDEN NAME Anna Geifarth			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown				16. SOCIAL SECURITY NO. Mrs. Melvin C. Wright, LaVale, Md.			
17. INFORMANT Mrs. Melvin C. Wright, LaVale, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (b) CORONARY SCLEROSIS (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> November 7, 1961 DATE SIGNED Address (Street, city, town, or county) Cumberland, Md.							
ACTUAL SIGNATURE Benedict Skitardlic		EXAMINER'S NAME (Type) Benedict Skitardlic, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/61		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Maryland	
23. FUNERAL DIRECTOR Louis Stair Inc.				24a. REC'D BY REGISTRAR NOV 10 '61			
24b. REGISTRAR'S SIGNATURE Arthur S. Hume				24c. REGISTRAR'S SIGNATURE			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN '1b 2/20/1960			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Laura Middle B. Last Zimmerman				4. DATE OF DEATH Month November Day 13 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/12/1873	
9. AGE (In years last birthday) 88 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Amity, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
13. FATHER'S NAME John Kelly				14. MOTHER'S MAIDEN NAME Sarah Clutter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT P.O.Box 599 Address Cumberland, Md.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocarditis, chr. degenerative. 422.1 DUE TO (b) Arteriosclerosis. Senile psychosis. DUE TO (c) Fracture. Right hip (old)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2/20/60 19 to 11/13/61 19, that (I) (we) last saw the deceased alive on 11/13/61 19, and that death occurred at 1:15 P.M. M, from the causes and on the date stated above.							
22a. SIGNATURE L. B. Mathews M.D.				22b. DATE SIGNED 11/14/61			
22c. PHYSICIAN'S NAME (Type) L. B. Mathews M.D.				22d. ADDRESS 49 Greene St., Cumberland, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 15, 1961			
23c. NAME OF CEMETERY OR CREMATORY St. Luke's Cemetery				23d. LOCATION (City, town, or county) (State) Cumberland, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				25a. REC'D BY REGISTRAR DATE NOV 17 '61			
				25b. REGISTRAR'S SIGNATURE Arthur S. Howe			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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